ENHANCING ACCESS TO CARE AT HOME IN RURAL AND UNDERSERVED COMMUNITIES

HEARING

BEFORE THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

MARCH 12, 2024

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United States House Committee on
Ways & Means
CHAIRMAN JASON SMITH

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Chairman Smith Announces Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

House Committee on Ways and Means Chairman Jason Smith (MO-08) announced today that the Committee will hold a hearing to examine opportunities and challenges in enhancing access to care in patients' homes and modernizing care in rural and underserved communities. The hearing will take place on **Tuesday, March 12, 2024, at 11:00 AM in 1100 Longworth House Office Building.**

In view of the limited time available to hear the witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record can do so here: WMSubmission@mail.house.gov.

Please ATTACH your submission as a Microsoft Word document in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 26, 2024**. For questions, or if you encounter technical problems, please call (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission but reserves the right to format it according to guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written

comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Please indicate the title of the hearing as the subject line in your submission. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

ACCOMMODATIONS:

The Committee seeks to make its facilities accessible to persons with disabilities. If you require accommodations, please call 202-225-3625 or request via email to WMSubmission@mail.house.gov in advance of the event (four business days' notice is requested). Questions regarding accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the Committee website at http://www.waysandmeans.house.gov/.

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ENHANCING ACCESS TO CARE AT HOME IN RURAL AND UNDERSERVED COMMUNITIES

TUESDAY, MARCH 12, 2024

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The Committee met, pursuant to call, at 11:07 a.m., in Room 1100, Longworth House Office Building, Hon. Jason T. Smith [Chairman of the Committee] presiding.

Chairman SMITH. The committee will come to order.

Today millions of Americans are able to get access to quality health care right in their home because of advancements and new flexibilities implemented by hospitals and doctors for the patients they treat.

Over 3.2 million patients across America chose to receive infusion therapy at home. One in four adults use telehealth every month, and nearly fifty million Americans use some sort of remote-monitoring service. These technologies are helping providers coordinate care across different health settings, and bring quality care from your doctor's office and even hospital to your living room.

The results show that at-home care can be better for patients' health and wallets. At-home dialysis has been a game-changer for patients. Those patients have a 40 percent lower mortality rate, and they recover faster than those treated at a physical dialysis center. At-home infusion can cost up to 60 percent less than infusion performed in a hospital or doctor's office.

Not surprisingly, at-home care is massively popular with patients. More than 90 percent of Medicare Advantage enrollees using telehealth have a favorable opinion. Over 90 percent are satisfied with their remote patient monitoring, care, and assistance.

Where someone lives, works, or raises a family should not be a barrier to getting top-of-the-line health care. One of our priorities on this committee is helping every American get health care in their community.

For patients in rural and underserved communities, bringing health care home is a lifesaver. These communities struggle with access to health care, which results in worse health outcomes compared to wealthy, urban areas. Americans living in small towns often have fewer health services close by, and rural Americans have to drive farther to get critical care. We are already seeing these patients take advantage of care-at-home options. Rural ESRD patients, for example, are 22 percent more likely to receive dialysis at home compared with their urban counterparts.

Audio-only telehealth increases access for rural and underserved Americans who lack reliable Internet. In the 28 counties I represent back in Missouri, there are plenty of spots that have bad Internet. You can forget about a Zoom call with your doctor. And I know I am not the only person on this committee who can say that.

We are here to discuss the benefits of these advancements for our constituents, while recognizing that the Medicare telehealth and hospital at-home flexibilities that make at-home care possible are both set to expire at the end of this year.

The consequences of these policies expiring would wreak havoc for patients and doctors now accustomed to providing care at home. Medicare patients would no longer be able to receive telehealth care from home, and patients receiving hospital at-home care will have to go back to the hospital, limiting bed availability for other patients. Doctors and providers will yet again face more uncertainty and will be left scrambling to figure out the best way to take care of these patients.

At the same time, we cannot accept the same tired approaches that have not made a meaningful difference for enough patients. Before today's hearing I had the chance, along with members of the committee, to see some of the cutting-edge technology that could help better address the unique needs of rural and underserved communities and expand access to care through innovation. We have to explore new approaches that have the potential to help make Americans healthier and allow rural Americans to get care when and where they need it.

Home dialysis, infusions, and remote patient monitoring can be better utilized by investing in patient assistance and examining provider reimbursement. Additionally, meaningful patient and taxpayer protections should be considered to ensure robust access, demonstrate value, and prevent waste, fraud, and abuse.

Importantly, health at home should be considered a supplement to quality, in-person care. Hospitals and doctors' offices are and will always remain critical pieces of our health care system that millions of patients rely on, and we are happy to have their support in leveraging this new technology.

Still, Congress must help patients who want more control and flexibility over their health care, especially those with chronic conditions or living in rural and remote areas. I look forward to working with my colleagues to find ways we can preserve and protect health-at-home options that serve families and seniors across our country.

Chairman SMITH. I am pleased to recognize the ranking member, Mr. Neal, for his opening statement.

Mr. NEAL. Thank you, Mr. Chairman, and this is a good opportunity, I think, for a pretty good hearing to discuss a series of challenging issues.

But I also want to thank the work of House Democrats, who have reached historic health care milestones that continue to improve the lives of the American people. More Americans have health insurance today than ever before, with 4 out of 5 people now being able to access high-quality care for less than $10 a month. The American people have trusted us when it comes to protecting their

access to health care, and for good and obvious reasons. This committee is the birthplace of those sacred promises that were made to the American people, and Ways and Means Democrats will not back down from defending the economic, security, and peace of mind that we have given to workers and retirees from political threats.

I never miss the opportunity in quiet moments here to reflect upon one portrait on the wall to my left, in which Mr. Mills, who was the chairman of the committee from Arkansas, embraced the idea of Medicare. Even though his enthusiasm was limited at the beginning, when Lyndon Johnson got done his enthusiasm was necessary to get the legislation over the goal line, always recalling that Medicare is an amendment to the Social Security Act. And as President Biden noted the other night, there will be no changes on his watch to the guarantee of these initiatives.

While today's hearing is an important look at the emerging forms of health care, we want to make sure that there are no efforts that would dismantle the ACA or the health care system as we have improved it. Home-based health care played a key role in connecting Americans with medical care during COVID–19 and the pandemic. The celebration of that famous statement from Dr. Fauci was yesterday. It continues to be a point of focus for policy-makers, and more services are being offered today at home.

As we examine the current use and potential expansion of home care-based services, this committee must consider how these services impact patient outcomes, health equity, taxpayers, and caregivers, and implement data-driven solutions that promote value for beneficiaries.

I have actually participated in home health care visits with advocates. What we pay for and how we pay for it will affect patients' costs and access to care for the foreseeable future. Promoting health equity in home-based services is a priority for our proposals to expand Medicare.

Current infrastructure weaknesses make it impossible for rural and underserved communities to rely on telehealth and other home-based care alone. Democrats delivered a generational investment in our nation's infrastructure with the Bipartisan Infrastructure Law, and we now must continue to make sure that Internet access is available to all members of the American family that will connect rural and underserved communities with access to home-based health care.

Caregivers must also be at the center of this policy discussion. We have more than 48 million family caregivers in America, too many of whom find it difficult, if not impossible, to coordinate health care for their loved ones. While care in the home can help caregivers in coordinating care, care in the home can also rely on already overburdened caregivers as they must attend to their loved ones' daily needs.

Four years ago, as I noted, to the day, we were locked down in a great state of uncertainty. The following months consisted of heartbreak that took too many lives and stretched our health care system like never before, all while some ignored the science and put millions of lives in danger.

When Joe Biden took office, that life returned to normal. We did what was needed to get done in terms of shots in the arms, and millions of people went back to work in record time, and ultimately put the health and well-being of the American people first. His progress and promises continue to be outstanding, and we certainly do not intend to go back.

I am grateful for the witnesses for being here today. They are well chosen, and we look forward to hearing their testimony.

Mr. NEAL. Thank you, Mr. Chairman.

Chairman SMITH. Thank you, Mr. Neal. I will now introduce our witnesses.

Bell Maddux is a home dialysis patient and a working mother.

Roy Underhill is a Hospital at Home patient.

And Dr. Nathan Starr is a medical doctor and lead hospitalist of Tele-Hospitalist Program for Intermountain Healthcare.

Chris Altchek is founder and CEO of Cadence.

And Dr. Ateev Mehrotra is professor of health care policy and medicine at Harvard Medical School at Beth Israel Deaconess Medical Center.

Thank you for joining us today. Your written statements will be made part of the hearing record, and you each have five minutes to deliver remarks.

Mrs. Maddux, you may begin.

STATEMENT OF BELL MADDUX, HOME DIALYSIS PATIENT AND WORKING MOTHER

Mrs. MADDUX. Hello, and thank you for inviting me to testify before this committee today. My name is Bell Maddux, and I am a home hemodialysis patient. Currently I live with my husband and my two children in Tobyhanna, Pennsylvania, which is a lovely rural area in the Pocono Mountains.

[Slide]

Mrs. MADDUX. I was diagnosed with kidney disease as a teenager, and in 2008 I was fortunate to receive a living kidney donation from my father. That kidney lasted me 10 years, and allowed me the amazing gift of becoming a mom. However, in 2018, despite 10 years of good health, perfect labs, perfect blood pressure, I started experiencing signs of kidney rejection.

I was standing on West Fourth Street in New York on my way to work, when my nephrologist called from her vacation and yelled through a bad connection that I needed to get to the emergency room immediately. From that point my health plummeted. I was unable to eat, and my weight went down to a number I hadn't seen since I was about 12 years old.

At that time we were living in Newburgh, New York, which is about an hour outside of New York City. And for four months I struggled making my daily commute into the city to work. I would drive to the train station, then take the train to the subway. But by the time I got to my last subway transfer, I could only take a few steps at a time without having to rest on a subway support beam. Once at work I found it difficult to have enough strength to stay in my chair all day, and I would often find a back room where I could do my work laying on the floor.

Dialysis had been a longstanding fear of mine, but now it was time to start. And before my first treatment I sat in my car outside of the dialysis clinic and struggled to breathe. But I went in and I began my life as a dialysis patient. And once I felt the effects of it, I realized how much I needed it to function in my day-to-day.

Three days a week I sat in a chair for three hours straight, while the while the machine, dialysis machine, did seventeen percent of the work that my kidneys should have been doing continuously. The clinic was only five minutes away from my house, but my life quickly became dominated by getting to and doing treatment. Every Tuesday, Thursday, and Saturday I had to arrive at around 1:30 to prepare for a 2:00 p.m. chair time. And by the time I left, it was about 5:30. Saturdays with my family were completely gone, and things like birthday parties and soccer matches I just had to miss.

I am thankful that my company allowed me to work from home on those two days, so I could bring my laptop with me to continue working during my chair time. I did want to maintain my 15-year career as a digital project manager, but I also wanted to be valuable to my team. But participating in client calls and team meetings became impossible with machine alarms constantly beeping and frustrated patients in distress. It was difficult. It was a difficult place to be for so many reasons.

Many of the other patients had mobility issues and relied on medical transport services to bring them from their home, which could sometimes be 45 minutes away. One very kind man told me at one point that he did nothing else in his life except go to dialysis and then wait to go to dialysis. I didn't know much about home dialysis at that time, but being already overwhelmed with two small children and failing health, I was reluctant to take on any added responsibility. But clinic life had become too difficult.

My doctor explained that doing more frequent treatments would be easier on my body, and I would get some relief from the physical symptoms that I had been experiencing. So I went to the floor nurse and I asked for an appointment with the home training nurse, and they all seemed excited, gave me a few folders and papers to read. But then I heard nothing for a few weeks. Follow-up calls from me and my doctor got no response. And finally, the scheduled appointments that I had made was made during the nurse's vacation.

I was also trying to coordinate a move from New York to a larger home in Tobyhanna, Pennsylvania, but I was getting nowhere with making this transition. My doctor was equally frustrated, and handed me the private cell phone number of a home dialysis nurse at another center. My new nurse took care of everything, including training me how to insert the 15 gauge needles into my own arm, how to rotate the needle positions to avoid damaging my access, how to draw and process my own blood for labs, and how to administer my own medication.

After the first week my energy was up, my symptoms eased, my diet and fluid struggles disappeared. I even got comments on the improvement in the pallor of my skin. So today I do my dialysis treatments at home and my entire day is free every day. After I make dinner I take 10 minutes to set up the machine, I lay out my

supplies. Then I can do a quick bath time and bedtime stories with my kids, and even squeeze in a quick tidy-up before I take my vitals, settle in with my electric blanket and a movie.

Now I can choose to do my work during treatment, or I can choose to do my treatment after work. When I am done I can be pretty wiped out still. But instead of getting behind the wheel of my car, I can take three steps and get in my bed. It also means that my free time is no longer devoted to preparing for or recovering from treatment. I do still travel two hours twice a week to my office in New York City, but now, thanks to home dialysis, I have the energy for the long commute and also for the long work day after.

My initial perception of being on a home dialysis patient was not wrong. It is a lot of work. It is not without risks, and it is not for everyone. But the benefits are so much that I think every person who is on dialysis should be empowered with the choice and armed with the support and sufficient information to make the right choice for themselves.

My younger son doesn't remember me ever being in clinic, but my daughter remembers wishing I did not have to go all the time, and they both prefer to have me at home. Having that choice is second only to having a working kidney. Thank you.

[The statement of Mrs. Maddux follows:]

Statement of Bell Maddox
Home Dialysis Patient

Hello, and thank you for inviting me to testify before this committee today. My Name is Bell Maddux and I am a home hemodialysis patient. I was diagnosed with kidney disease as a teenager and in 2008 I was fortunate to receive a living kidney donation from my father. That kidney lasted me 10 years and allowed me the gift of becoming a mom to my two amazing children. However, in 2018 I started to experience signs of kidney rejection. After 10 years of good health, with perfect labs, perfect blood pressure, I started to show elevated creatinine numbers, and my blood pressure was getting higher with each appointment. I was standing on West 4 Street in NY, on my way to work, when my nephrologist called from her vacation and yelled through a bad connection that I needed to get to the emergency room immediately.

From that point, my health plummeted. I was unable to eat. My weight went down to a number I hadn't seen since I was twelve years old. For four months, I struggled making my daily commute from the Hudson Valley to work in New York City. Driving to the train station, then the train to the subway, by the time I got to my last subway transfer, I couldn't take more than a few steps at a time without stopping to rest on a support beam. At work, I found it difficult to stay in my chair all day, and often had to retreat to a back room where I could do my work laying on the floor.

Dialysis had been a long-standing fear of mine, but now it was time to start. One week after I had the procedure to insert the tunnel catheter into my jugular, I sat in my car outside of the dialysis clinic, struggling to breath. But I went in and began my life as a dialysis patient. Once I started, and felt the effects, I realized how much I needed it to continue functioning in my day-to-day.

Three days a week, I sat in a chair for three hours straight while the dialysis machine did 17% of the work that my kidneys would have been doing continuously. The clinic was five minutes away, but my life quickly became dominated by getting to and doing treatment. Every Tuesday, Thursday, and Saturday, I had to arrive at around 1:30 to prepare for a 2pm chair time. By the time I left, it was 5:30. Saturdays with my family were completely gone, and things like birthday parties and soccer matches, I just had to miss. I am thankful that my company allowed me to work from home on those two days, so I could bring my laptop with me to the clinic to continue working during my chair time. I wanted to maintain my 15-year career as a digital project manager. I also wanted to be valuable to my team, but participating in client calls and team meetings was impossible with the machine alarms constantly beeping and patients in distress, or just getting loud in frustration. With just one nurse and two technicians, I also felt I had a front row seat to the workplace politics and constant changing requirements that had little to do with patient care that bogged down the staff. It was a difficult place to be in for so many reasons. Many of the other patients had mobility issues and relied on medical transport services to bring them from their home, sometimes 45 minutes away. One very kind man told me that he did nothing else in his life, except go to dialysis and wait to go to dialysis. Urged by one of the nurses, I decided to change to another center that was further away.

And this one was much better, even though there was still background noise during work calls, the staff did what they could to accommodate me. But then things got more complicated. I was notified by the clinic's financial coordinator that my insurance company was not paying for my treatments. Apparently while everything else was covered, this particular location was out of network. The insurance company sent me to a location and a new doctor that was twice the distance away. It was at this clinic, where I experienced a painful infiltration for the first time. It was at this clinic that I started experiencing muscle weakness and had a hard time walking again. My doctor discovered that the staff inexplicably stopped administering the medication that sustained my hemoglobin levels. Of course, this was in 2020 and Covid was sweeping through crowded clinics, and I was hearing about dialysis patients like me catching it in the clinic and dying.

I was often asked why I was not automatically choosing home dialysis, and I didn't know much about it, but being already overwhelmed with two small children and failing health, I was reluctant to take on the added responsibility. But after this series of terrible experiences, I felt that there was no choice, I had to get out of that clinic. My doctor explained that doing more frequent treatments would be easier on my body, and I would get some relief from the physical symptoms I was experiencing. I went to the floor nurse and asked for an appointment with the home training nurse. They all seemed excited, and gave me some folders, and papers to read, and then I heard nothing for weeks. Follow up calls from me and from my doctor, got no response, and finally the scheduled appointment was made during the nurse's vacation. I was trying to coordinate a move to a larger home in Pennsylvania but was getting nowhere with making this transition. My doctor was equally frustrated and handed me the private cell phone number of a home dialysis nurse at another center.
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My new nurse took care of everything, including training me how to cannulate myself, how to rotate needle positions to avoid damaging my access, how to draw and process my own blood for labs, and how to administer my own medication. After the first week of training, and doing consecutive treatments, my health improved exponentially. My energy was up, my symptoms eased, and my diet and fluid struggles disappeared. I even got comments on the improvement in the pallor of my skin.

Today I do my dialysis treatments at home. What that means is that my entire day is free, every day. After I make dinner, I take ten minutes to set up the machine, and lay out my supplies. Then I do bath time and bedtime stories with my kids, maybe squeeze in a quick tidy-up before I take my vitals and settle in with my electric blanket and a movie. Now, I can choose to do work during treatment, or I can choose to do treatment after work. When I'm done, I can be pretty wiped out, but instead of getting behind the wheel of my car, I take three steps and get in my bed. It also means that my free time is no longer devoted to preparing for or recovering from treatment. Since my body is no longer able to process liquids, the accumulation of fluid in my body, around my lungs and heart, between treatments had been my biggest challenge. Having enough discipline to drink less than 30oz over two days, while my body was screaming to have a

tall, dripping glass of ice water, is the closest I ever want to come to being in Hell again. Now, if I'm thirsty, I can have juice, or water, or root beer, and if I ever overdo it, I can do an extra treatment to remove the excess fluid.

My initial perception of being a home-dialysis patient was not wrong. It is a lot of work, especially having opted to be a solo patient, which means that I do everything myself without the help of a caregiver. Sort of like driving a car, it's definitely not without risks and it's not for everyone. But the benefits are such that I think every person on dialysis should be empowered with the choice and armed with support and sufficient information to make the right choice for themselves. My son doesn't remember me ever being in clinic, but my daughter remembers wishing I didn't have go all the time. They both prefer to have me at home. Having that choice is second only to having a working kidney.

Chairman SMITH. Thank you.
Mr. Underhill is recognized.

STATEMENT OF ROY UNDERHILL, HOSPITAL AT HOME PATIENT

Mr. UNDERHILL. Good morning, Chairman Smith, Ranking Member Neal, and members of the committee. My name is Roy Underhill, and I have traveled here today from Saxapahaw, North Carolina, where I have lived with my wife in an old mill on Cane Creek for about 15 years. Our nearest neighbors are wood ducks, bobcats, and river otters. My primary occupation is studying and teaching about early American woodworking. I am honored to be here today with you, and thank you for inviting me to testify at today's hearing on enhancing health care at home in our rural and underserved communities.

Now, one landmark of our old mill where I live is the dam and waterfall of the mill pond. Throughout 2021 I had been suffering with urinary blockage from prostate enlargement, and I assure you that the aggravation of urinary blockage is not enhanced by the constant sound of a waterfall by your house.

Resorting to a urinary catheter for relief, I apparently induced an E.coli infection into the works. This infection began to spread. And on a Sunday evening, November 7, 2021, I began feeling waves of chills and trembling. My temperature was climbing, and I was sweating profusely. I became disoriented, verging on delirious, and my wife, Jane, managed to get me into the car and drove me to the emergency room over in Chapel Hill as fast as she could.

Unfortunately, this was also the evening of a football game in Chapel Hill, and the emergency room was packed with students suffering from alcohol-related mishaps and malaise. It was also the high time of COVID, which added significantly to the crowd.

I was eventually diagnosed with sepsis, a potentially deadly situation where the bacterial infection had spread throughout my body. They began treatment with intravenous antibiotics, and the doctor told me that I came close, but I was not going to die: information I was greatly reassured by. He said my course of treatment would require a hospital stay of at least three days. But there was an alternative, a new program where I could continue treatment at home, rather than in the hospital if I qualified.

Well, I enthusiastically expressed my desire to pursue this option, and they began the questions regarding the suitability of my home for this new program. Once they determined that I qualified, they dispatched a team out to my home, where they began installing the technical equipment that I would need to stay connected to my care team at the hospital. They prepared a downstairs bedroom with a wireless connection to the hospital, a direct phone line, an emergency button, and a dedicated visual link. All of this was installed on the bedside tables of my bedroom.

When I returned home from the hospital that afternoon, all this equipment was in place, and the medical staff was there to explain the equipment and show me how to work it. I learned how to pull up my schedule for each day, and how to operate all the equipment. I slept very well that night with my pets, and my books, and my own bed, with my bed clothes, my own—and the next day

neighbors and friends were able to stop by and bring me chicken soup. Now, they would not have been able to visit had I been in the hospital.

Twice or more a day, medical professionals dropped by on their rounds through the countryside to check my vitals and administer the continuing antibiotic treatment. I saw my doctors, nurses, and paramedics both in person and virtually at least several times a day, and received all the medical services I needed. At any time I could check in through the video link with the doctors and nurses and make sure that I was recovering as expected.

I credit this Hospital at Home option with much of the excellent results of my treatment and recovery, as well as the absence of any dangerous complications that might occur from hospital-induced infections. The program freed up a hospital bed for those who might need it more, and I was happy at home in my own room and Jane's home cooking. The program worked great for me. And the thinking of my other rural neighbors, it is an option that I am sure could do a lot of good for a lot of folks. For me it was great.

I do like old tools and techniques, but when it comes to health care, I am a big fan of the 21st century. I hope you can find a way to keep this excellent program going. Thank you for providing me with the opportunity to testify today, and I look forward to any questions you might have later on. Thank you.

[The statement of Mr. Underhill follows:]

Statement of Mr. Roy Underhill for the

Committee on Ways and Means of the U.S. House of Representatives

"Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

Good morning, Chairman Smith, Ranking Member Neal, and Members of the Committee.

My name is Roy Underhill and I have traveled here today from Saxapahaw, North Carolina, where I have lived with my wife for 15 years in an old mill on Cane Creek in Alamance County. Our nearest neighbors are wood ducks, bobcats and river otters. My primary occupation is studying and teaching about early American woodworking. I am honored to be here with you today and I thank you for inviting me to testify at today's hearing on enhancing access to health care at home in our rural and underserved communities.

One landmark of the old mill where we live is the dam and waterfall of the mill pond. Throughout 2021, I had been suffering with urinary blockage from prostate enlargement. One might understand that the discomfort of urinary blockage can be made all the more aggravating when accompanied by the constant sound of a nearby waterfall. I finally had to resort to a urinary catheter for relief. In November of 2021, during a change of catheter, I apparently induced an e-coli infection into the works.

This infection began to spread from my urinary tract to the rest of my body, but I did not know that until Sunday evening, November 7th, 2021. I was at home and began feeling waves of chills and trembling. My temperature was climbing and I was sweating profusely, becoming disoriented, verging on delirious. My wife, Jane, managed to get me to the car and drove me to the emergency room over in Chapel Hill as fast as she could, about 30 minutes away.

We arrived at the emergency room at 10 PM. Unfortunately this was also the evening of a basketball game in Chapel Hill and the emergency room was packed with students suffering from alcohol related mishaps and malaise. This was also in the high time of COVID which added significantly to the crowd. Thus, it was close to 4 AM before I could be seen.

Eventually, I was stabilized and they began treatment with intravenous antibiotics. I was diagnosed with sepsis, a potentially deadly situation where the bacterial infection

had spread throughout my body. In the morning, the doctor told me that I came close, but that I was not going to die, a reassurance for which I was most grateful.

Later, about mid-day, I was informed that my course of treatment, which, again, primarily involved intravenous antibiotics would require a hospital stay of at least three days. Although I was certainly glad of the modern medical cure for my condition, the prospect of three days in the hospital was not great news to hear. But this was quickly followed by the news that there was an alternative.

They told me of a new program where I could continue treatment at home rather than in the hospital—if I qualified. I enthusiastically expressed my desire to pursue this option, and they began the questions regarding the suitability of my home situation for this new program. The questions were extensive regarding if I had help at home, if I had electrical facilities, internet links, running water, a functioning toilet, my distance from the hospital emergency room, and so forth.

Once they determined that I qualified, they dispatched a team out to my home where they verified the suitability and began installing the technical equipment that I would need to stay connected to my care team. They prepared a downstairs bedroom with wireless connections to the hospital, a battery backup to maintain constant communication, a direct phone line, an emergency call button and a dedicated visual link through an iPad. All of this was installed on the bedside tables of my own bed.

When I returned home that afternoon, all this equipment was in place and medical staff was there to explain and test the equipment with me. I learned how to pull up my schedule of visits for each day, how to place and receive video calls with my care team, how to use the hardwired phone if the tablet was not working, and how to wear the personal emergency response system device so that I could reach my care team if I was not near the tablet or phone and needed help. This may sound complicated, but it was extremely simple and clear.

I slept well that night! I was home with my pets and my books and in my own bed and bed clothes. The next day neighbors and friends were able to stop by, one of whom, blacksmith Peter Ross, brought the best chicken soup I have ever enjoyed! These friends would not have been able to visit had I been in the hospital due to the COVID restrictions. Twice or more a day medical professionals dropped by on their rounds through the countryside to check my vitals and administer the continuing antibiotic treatment. All antibiotics were confirmed and administered under the watchful eye of the UNC hospital staff over the live video link.

There was never a moment when I felt alone. I saw my doctors, nurses and paramedics both in-person and virtually several times a day and received all the

medications, tests, treatments, therapies, and services I needed. At any time I could check in through the video link with the doctors and nurses at UNC hospital who made sure I was proceeding as expected in my recovery.

Indeed, my recovery from this dangerous condition was rapid and complete. I credit the hospital at home option with the excellent results of my treatment, as well as the absence of any dangerous complications that might occur from hospital induced infections.

As a result of my direct experience, I became an enthusiastic advocate of the hospital at home program and went out of my way to inform the hospital that, if they needed endorsement of the program, I was ready and eager. That is why I am here today, representing only myself and my experience.

In addition to my good experience, the potential of the program appeals on many levels. Because I was not in the hospital, that hospital bed was free for those who might need it more. I was happy at home with my own room and Jane's home cooking. I never felt concerned that I was away from the hospital, as my condition was being checked as often as it would have been had I been in the big building in town. The program worked well for me and thinking of my rural neighbors, it is an option that could do a lot of good for the country folk.

I am fortunate to have access to the care I need both at the university hospital and at home. As I understand it, this program was created during the COVID pandemic as a way to keep people out of the brick and mortar hospitals and to increase capacity for those who needed to be hospitalized for COVID. However, I am grateful that Congress has acted once before to extend this program. I hope that as you debate and consider legislation that brings health care innovation to the home, you will find a way to ensure hospitalization at home continues to help more patients than ever before.

For me, the program was great! I do like old tools and techniques, but when it comes to health care, I am a big fan of the twenty-first century!

Thank you for providing me with the opportunity to testify before you today. I look forward to answering questions should you have any.

Chairman SMITH. Thank you very much.
Dr. Starr, you are now recognized.

STATEMENT OF NATHAN STARR, M.D., LEAD HOSPITALIST OF TELE–HOSPITALIST PROGRAM, CASTELL HOME SERVICES, INTERMOUNTAIN HEALTHCARE

Dr. STARR. Chairman Smith, and Ranking Member Neal, and members of the committee, my name is Dr. Nathan Starr, and I am an internal medicine physician with Intermountain Health. As part of my role I am medical director of home services, which includes our Hospital at Home and our home-based primary care programs. I also direct our tele-hospitalist program, which involves providing virtual care for patients in rural hospitals.

Intermountain Health is the largest health care provider in the Intermountain West, covering seven states, including a large rural presence within our own footprint, as well as providing telehealth services in many rural communities outside of our footprint.

Intermountain views moving care away from hospitals as essential to our mission of helping people live the healthiest lives possible. A key element of that shift is increasing the provision of care in the home. The directive I received from our CEO, Rob Allen, about our Hospital at Home program was to simply grow. In 2020 we stood up a Hospital at Home program as fast as we could in response to the pandemic.

There are two ways that patients enter our program. They are admitted from the emergency department to home, or they are patients who are transferred home to complete their hospitalization following an admission.

Taking care of patients for the last four years in their homes has dramatically changed how I view health care. In a hospital or clinic we only get a snapshot of the patient, while being in the home allows us to truly understand them. We have many patient successes within our program, and for the sake of time I refer you to my written testimony to see those examples, and I greatly appreciate the two examples that have been shared with us today.

With our focus on value-based care, Intermountain plans on investing heavily in moving care to patients' communities and homes, guided by five principles.

First, the care we give must be of equal or better quality than what the patient would receive at the hospital.

Second, the patient experience must be at least as good, if not better.

Third, we must show that we have cost savings that make this financially beneficial for the hospital, health system, payer, and the patient.

Fourth, these programs must improve the working experience of our employees and providers, especially an opportunity with nurses. We can help them stay in health care and utilize their expertise in a way that prevents burnout and provides growth. For us the experience has been so positive that our health care—for our health care providers that we have a waiting list to work in our tele programs.

Lastly, we need to ensure that we are providing needed care, not extra care.

At Intermountain we have provided Hospital at Home care to more than 1,200 patients, have had 0 serious in-home safety events, have seen lower hospital readmissions, fantastic patient experiences, and have freed up over 4,000 physical patient bed days. We are just beginning to scratch the surface of what we can do in the home and in communities. For example, in addition to Hospital at Home, we provide virtual night-time hospitalists and 24-hour intensive care support in rural communities. We provide virtual teleoncology services in rural communities, and my written testimony contains many more examples.

Lastly, today is the grand opening of a hybrid community health clinic that combines telehealth and in-person services in Wells, Nevada, a town of 1,200 people with the closest health care, prior to this clinic, a round trip of 100 miles.

On behalf of Intermountain Health and the Moving Health Home Alliance to which we belong, we urge you to pass the Expanding Care at Home Act introduced by Ways and Means Committee member Congressman Adrian Smith and Congresswoman Debbie Dingell. This legislation, H.R. 2853, will remove barriers that currently limit our ability to care for patients in the home.

We also urge a five-year extension of the current waivers to the Acute Hospital Care at Home Initiative. This will allow the needed time to gather data to develop a permanent regulatory, clinical, and financial model that will make Hospital at Home a success for everyone. If Congress fails to act to extend the Hospital at Home program, we will be forced to roll back the program and lose the important gains we have made.

What makes me so passionate and excited about moving care into the home is, if we do this right, then hospitals, health systems, communities, payers, and most importantly, patients will all win.

Thank you for the opportunity to appear before you today, and I am happy to answer any questions.

[The statement of Dr. Starr follows:]

Intermountain Health

Testimony of Nathan Starr, DO
Medical Director, Home Services and Tele-Hospitalist Programs
Intermountain Health

Before the United States House of Representatives
Committee on Ways & Means

Hearing on Enhancing Access to Care at Home
In Rural and Underserved Communities

12 March 2024

Chairman Smith, Ranking Member Neal, and Members of the Committee, thank you for the opportunity to appear before you today to share Intermountain Health's experience in leveraging technology to provide care in the home, including in rural and underserved communities. As the largest healthcare provider in the Intermountain West, Intermountain Health recognizes the need to support our rural and underserved communities and the opportunity to fulfil our mission by taking the same care found in large urban areas into rural and underserved communities. Over the last four years, Intermountain has dramatically increased its provision of care in the home – through acute care hospital level care at home, telehealth, and remote patient monitoring. I have personally seen patient, family, community, and caregiver benefits of care at home. Our positive experience has reinforced our commitment to increasing access to care at home. That is also why we are so pleased to be here today to advocate for the federal health policy changes needed to enable and support current and future hospital at home and patient needs.

I am Nathan Starr, a Doctor of Osteopathic Medicine. I joined Intermountain as a hospitalist in 2008 following my residency in internal medicine. Intermountain Health is a not-for-profit integrated health care delivery system, headquartered in Salt Lake City, Utah, with regional offices in Broomfield, Colorado and Las Vegas, Nevada. We are comprised of 33 hospitals – which includes our virtual hospital - around 385 clinics, medical groups with more than 4,200 employed physicians and advanced practice providers and a health plans division called Select Health. With approximately $14B in revenue, around 60,000 caregivers and serving over four million patients and more than one million health plan members, Intermountain provides services in seven states: Colorado, Idaho, Kansas, Montana, Nevada, Wyoming, and Utah. In addition to being both a provider and plan, Intermountain is also an innovation hub and has launched multiple companies seeking to address some of health care's most pressing challenges. These include companies focused on value-based care (Castell), generic pharmaceutical drugs (CivicaRx), and interoperability (GraphiteHealth).

Intermountain is committed to improving community health and we are proud to be recognized as a leader in transforming health care by using evidence-based practices and

leveraging health information technology to deliver high quality health outcomes at sustainable costs. Intermountain is committed to accelerating the transition from volume to value. Thus, Intermountain is deeply committed to engaging in federal health policy. Intermountain Senior Vice President for Policy Greg Poulsen serves on the Medicare Payment Advisory Commission (MedPAC), and Intermountain Primary Children's Hospital Chief Medical Officer Angelo Giardino, a pediatrician, serves on the Medicaid and Chip Payment Advisory Commission (MACPAC).

At Intermountain, the focus of our caregivers is on providing high quality care that is accessible and affordable to all by succeeding in our mission to help people live the healthiest lives possible.

Launch of Intermountain's Hospital Level Care at Home Initiative

In the early days of the pandemic, I was asked by Intermountain to develop a new Hospital Level Care at Home Initiative [HLCH] to address bed capacity issues in our larger hospitals. We operationalized this work through Castell, a comprehensive health platform company wholly-owned by Intermountain that is focused on elevating value-based care capabilities with providers, payers, health care systems and accountable care organizations. Castell works to expand on its foundation of lessons learned at Intermountain to offer cutting edge analytics and programs that enable a value-based care program to thrive and utilizing these resources has been a significant contributor to the program's success. In September of 2020, I was named Medical Director for Home Services for Castell, over the HLCH and Housecalls programs. Housecalls in a home-based primary care program for patients with medical and social complexity. In addition, since November 2020, I have served as the medical director for Intermountain Tele-Hospitalist program, which provides nocturnist services (physician night coverage) to five rural hospitals in Utah and consultative services to hospitals across Utah as well as in Nevada and Idaho.

Since 2020 Intermountain's HLCH service has expanded and is available at 16 hospitals across Utah.

These services are offered as an option to Intermountain patients who meet specific clinical and non-clinical criteria who come in through an emergency department (ED) visit or have been admitted to the hospital and can safely complete their hospitalization at home.

HLCH services are provided by in-person caregiver visits by Intermountain Health nurses, as well as remote monitoring and virtual visits by telehealth providers located at Intermountain Health's virtual hospital, which is located in Murray, UT. Intermountain Health's virtual hospital is staffed 24/7 by remote monitoring technicians, tele-nurses, tele-advance practice providers and tele-hospitalists who are available 24/7 to provide digital consultations depending on the patient's acuity.

HLCH also has access to consultations as clinically needed, including infectious disease, wound care, dieticians, and other hospital-based specialties. Some common diagnoses

that are seen include pulmonary embolisms, Covid-19, pneumonia, heart failure, cellulitis (bacterial skin infection), pyelonephritis (kidney infection), diverticulitis, gastroenteritis, dehydration and acute kidney injury, electrolyte deficient states, and complications of cancer treatment such as infections.

Since inception, HLCH has provided high-quality care to over 1,200 patients. Half of these patients are admitted directly to HLCH from the hospital ED, diverting a traditional inpatient admission altogether and keeping a bed open for more acute patients. The other 50% of patients have been transferred from an inpatient admission unit to finish their hospitalization in their home.

HLCH is working with Intermountain Health's strategy office on projects in Utah's rural communities where providers are scarce and resources to rebuild old hospitals are limited. The goal is to offset some of the projected beds needed with HLCH and to be able to provide more inpatient care to the rural communities by serving them in their homes. With the realization that some patients will always require a traditional hospital stay, there is an important opportunity to serve some key health care needs of rural, underserved, and vulnerable populations through HLCH and virtual acute care.

HLCH Statistics:

- >1,200 patients cared for (top 10% in program size)
- Zero serious in-home safety events.
- Average 7.5% 30-day readmission rate (compared to 9-11% for hospitals)
- Press Ganey Patient Satisfaction Likelihood to Recommend Score 85%
- Length of Stay - 3.2 days – similar to patients staying in hospitals.
- Over 4,000 bed days saved for hospitals

To illustrate the benefits of HLCH, I want to share a few brief patient stories:

A young male patient developed muscle breakdown after a new, intense gym workup, putting him at risk of kidney failure. He required admission for continuous IV fluids and monitoring of his kidney function. However, he lives in a multi-generational home and his role and responsibility was to watch younger family members after school so other family members could work outside the home. If he were in the hospital, there would be significant added stress to him and his family. We treated him at home, and he was able to fulfill his role in supervising younger family members.

An elderly male was treated at home for COVID. His second day home he was dizzy with a low blood pressure. We reviewed his medications and discovered that he was taking a blood pressure medication that no one seemed to know he was taking. We stopped the medication and gave him some fluids and his blood pressure and dizziness resolved.

A middle-aged male with diabetes was admitted with a leg infection. Once home, we discovered that his diabetes was poorly controlled because he needed to take his insulin very early in the morning due to his work. We adjusted his treatment regimen to fit his life and allow him to better control his diabetes.

A middle-aged female had a weakened immune system as a side effect of needed medications. She developed pneumonia and low oxygen levels and required hospitalization. In the past, she had acquired new infections while in the hospital. We treated her at home, and she healed quickly as her stress level was much lower than it had been in a hospital environment.

These are just a few of the stories from patients who were successfully treated through HLCH.

Telehealth and Remote Patient Monitoring

Intermountain Health has invested heavily in taking care to patients in their communities and homes through its telehealth and remote patient monitoring programs.

Telehealth Programs

Intermountain Health's Virtual Hospital is rapidly growing in number of specialties and communities served. We offer over 50 telehealth services in nine states (AZ, CO, ID, KS, MT, NM, NV, WY and UT) and with over 40 clinical partners, including 55 facilities from outside Intermountain Health. Many of these facilities are remote, critical access hospitals. Since 2016, we have completed over four million interactions, including over 79,000 transfers for patients requiring a higher level of care. Below are some program examples.

Stroke: Comprehensive virtual stroke evaluations and recommendations by stroke neurologists. We are supporting 38 hospitals with more than 16,000 patients served.

Crisis: Emergency Department (ED) virtual crisis evaluations for patients with mental health issues in all system Eds with 45% of patients able to transition home with outpatient support.

Patient Safety Monitoring: Monitor patients in hospital who are confused or at risk for falls via video which frees up hospital staff to cover other patient care duties. We've monitored over 3500 with no increase in falls or safety concerns.

Neonatology: Virtual evaluation and care of neonates at lower-level units by experienced neonatologists. This virtual care has yielded significant reduction in transfers and admissions, keeping babies and parents together in their communities.

Critical Care: There is a nation- and global-wide shortage of intensive care physicians. Via telehealth, we provide critical care support in hospitals without an intensivist, even in small community and rural hospitals. This helps keep patients in their community with equivalent care. Additionally, when a patient requires transfer to a higher-level facility, our intensivists help stabilize patients prior to transport, and ensure they are transferred to an appropriate facility by identifying the right level of care needed. This allows us to optimize all of the

available ICU beds. Observed versus expected mortality shows a reduction in mortality for patients who receive our services.

Infectious Disease: Provide virtual expert Infectious Disease consultations, which has shown reduced mortality, reduced readmissions, and reduced use of unnecessary antibiotics.

Hospitalist: Provide virtual nighttime coverage at rural hospitals for admissions and nurse questions. This is of particular value at rural facilities because the same provider often covers both day and night, leading to burnout and difficulty recruiting and retaining providers.

Oncology: Chemotherapy patients are treated in their communities with video visits from experienced oncologists. Benefits include decreased cost, no need for transportation, which helps with safety for older patients driving and time savings for patients. Patients stay in their communities with family and friends. Typically, in-person infusion times can last up to 12 hours, and if a patient needs to drive hours to get to infusion, each treatment could be a multiday trip.

Here is a testimonial from Clinical Manager Kimberlee Rowlett that speaks volumes:
"I personally have heard numerous times directly from patients that they would have "let the cancer take" them if they didn't have the TeleOncology program in their community."

For 849 patients receiving TeleOncology services in Richfield, Utah, the total drive time saved was 232,626 minutes, total drive distance saved was 280,170 miles, and total CO2 emissions saved was 103,214,628 grams.

Emergency Medicine: We have a new program supporting urgent care clinics who have patients they think need to go to the emergency room. An ED physician reviews data and does a video visit with the patient. The program has found that 94% of patients do not need an ED visit (average cost of $1,400 per ED visit). We are currently expanding into rural areas.

<u>Case Study in Wells, Nevada: Leveraging a Virtual/In-Person Hybrid Model to Bring Care to a Small Rural Community Lacking Health Care</u>

Wells, Nevada is a town of 1,243 people with no local physician or health care. Because of clinic closures, residents must travel 100 miles round trip to receive care. Intermountain Health partnered with city leaders to set up a financially viable option leveraging virtual care. This hybrid clinic opens today, March 12, 2024.

Objectives:

- Help patients avoid unnecessary travel.
- Provide in-town option for routine care, labs, simple procedures.
- Create sustainable financial plan.

Hybrid Model:

- Operated by Intermountain Telehealth and staffed with EMTs.
- City of Wells, NV provides clinic building.
- Operates two days per week with EMTs under the supervision of a virtual primary care provider.
- Primary Care Provider visits clinic monthly for physical exams and procedures.
- Utilize other telehealth care when clinic visit is not needed such as urgent care and behavioral health.

Remote Patient Monitoring

Intermountain Health uses multiple technology platforms to efficiently extend care across our footprint. HLCH is a prime example. Below are some other examples.

COVID mini-kit program:

During COVID, we provided Bluetooth enabled pulse oximeter to patients with COVID with risk factors for severe disease. Over 14,000 patients were discharged home with RPM. Outcomes showed this to be a safe, effective way to monitor patients with COVID at home, and identify patients who needed to come back to the Emergency Department.

Intermountain Health and Omada

As stated earlier, Intermountain Health focuses on innovation and health care transformation and is committed to delivering better care and improving outcomes at lower costs. This pursuit led to a partnership with Omada Health, Inc., a virtual, chronic disease prevention and management company that works with health care systems to improve access, outcomes, and compliance with chronic disease prevention and management. The program offers asynchronous care, dedicated human health coaches, connected devices, an app for tracking, lessons, and access to online peer support groups. The initial partnership launched in 2016 and provided access to Omada's Prevention program to Intermountain's patients followed by it becoming a covered benefit for employees in 2019. The collaboration in Utah expanded in 2020 with launch of an Omada Diabetes Prevention Program (DPP) demonstration project. A significant outcome demonstrated by Intermountain's DPP with Omada is having reduced the conversion rate from prediabetes to type II diabetes (T2D) in under three years from 58% in 2018 to <6% in 2021. Other meaningful results shown among the 6,000+ employees, patients, and community members who have participated in Omada's DPP across the Intermountain Health catchment area include an average satisfaction rate of 85%, engagement above Omada's national benchmarks, and analyses showing net positive savings from the program. These

results led to expanding the partnership again in 2023 through a new risk-based contract administered by Castell offering broader access to Omada's DPP and Diabetes Management program to help support qualifying patients in between provider visits. Early analysis of year one results are showing Omada has positively impacted weight loss, engagement, and hemoglobin A1C outcomes.

Another important benefit of this partnership is that Omada uses cellular technology for the devices its program uses, rather than less-widely available wifi networks, with the intent to have the program work in rural, suburban and urban areas. Omada health coaches also personalize the program by addressing social risks and other potential barriers to enable an individual to successfully achieve the best health outcomes.

Home Infusion:

Intermountain's Homecare Pharmacy is licensed in 7 states and has locations in South Jordan and St. George Utah. They provide infusion (IV) and enteral (tube feed) services to patients across Utah and the Intermountain West. This includes IV treatments for infections, cancer, heart failure, hospice and immunodeficiencies. On average, Intermountain's Homecare Pharmacy has 1,500 active patients receiving infusion services, many of them in rural areas. Intermountain's Homecare Pharmacy has been vital for the success of HLCH and our TeleOncology programs by delivering IV therapies to patients across our geography.

Future Opportunities

Historically, the hospital is the center of a health care system. However, a patient's home and community are the center of a patient's health and wellness. Over and over, we have seen the benefit of moving care into a patient's home. What is so exciting about this work is the impact we can see from individual patients and their stories. To truly understand someone and their health, nothing is more valuable than seeing them in their home and community. Hospital at Home, telehealth and technology like remote patient monitoring have opened up a new world of possibilities that are only beginning to be envisioned.

Addressing Barriers to Enhancing Care at Home in Rural and Underserved Areas

On behalf of Intermountain Health and the Moving Health Home Alliance to which we belong, we urge you to pass the "Expanding Care in the Home Act" introduced by Ways & Means Committee member Congressman Adrian Smith and Congresswoman Debbie Dingell. This legislation, HR 2853, would remove barriers currently limiting patient access to care in the home, which is often the preferred site of care for patients, caregivers, and providers. It would ensure home-based care is a viable option for patient care and scalable for providers.

We also urge a five-year extension of the current waivers to the Acute Hospital Care at Home initiative. CMS launched this initiative in November 2020 in response to challenges faced by hospitals following the spread of COVID-19. The initiative, which is currently set to expire at the end of 2024, allows certain hospitals to treat patients at home with in-patient

level care. It is important to ensure a five-year extension so there is enough time to invest in and expand hospital at home programs and allow time to continue to study the clinical outcomes and cost impacts, which thus far have demonstrated very positive results. Indeed, evidence shows that home-based acute care delivers the same or better outcomes with lower costs than facility-based care. Lower costs can be attributed to both a lower cost of care in the home and cost savings from reductions in readmissions.[1][2][3] Intermountain is setting goals for growth in HLCH admissions for multiple hospitals who either run at capacity or are going to be rebuilt due to age. The message we received from our CEO Rob Allen was very simple: "Grow!".

Barriers/Issues/Problems:

CMS Acute Care at Home Waiver tethers patient care to a specific hospital, making it more challenging to use the resources of a health system to efficiently run programs.

CMS Acute Care at Home Waiver allows for little flexibility in care delivery, which often makes care more expensive. For example, every patient requires two in-person visits daily, even if one visit with additional telehealth visits would provide the care a patient needs.

Provider licensure and credentialing for telehealth across state lines is very expensive and cumbersome.

Payers have variability in covering telehealth encounters which can greatly affect rural areas with limited options for care.

Acute Hospital Care at Home has two patient populations- patients admitted from the emergency department to home, and patients transferred home to complete their hospitalization following an admission to the hospital. Each population would benefit from a distinct reimbursement structure as the opportunities for cost savings do not fully overlap.

Protecting against fraud and waste by ensuring patients are receiving an appropriate level of care, not more than what they need.

Medicare coverage for home infusions is often incomplete, requiring many patients to get infusions in hospitals or skilled nursing facilities, typically at a higher cost and with great burden to the patient and their families.

Conclusion

Hospital at Home is a safe, effective model of care that benefits patients, health care systems, hospitals, and payers. There are many Hospital at Home programs functioning across the country, all identifying solutions to problems that are particular to their communities. The CMS Waiver has been key to the expansion and stability of Hospital at Home. Many states and payers use the Waiver as a basis for their successful programs.

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[1] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2685092
[2] https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780783
[3] https://www.acpjournals.org/doi/10.7326/0003-4819-143-11-200512060-00008

But the current version of the waiver is not a finished product. We need additional time to continue to collect data and create the best long-term model.

Thank you for your attention to these very important topics and the opportunity to testify.

Chairman SMITH. Thank you.
Mr. Altchek, you are now recognized.

STATEMENT OF CHRIS ALTCHEK, FOUNDER AND CEO, CADENCE

Mr. ALTCHEK. Thank you, Chairman Smith, Ranking Member Neal, and distinguished members of the committee. I am honored to speak with you today on a bipartisan topic: How we find solutions to the dramatic access challenges affecting patients and families living in rural and underserved communities.

My name is Chris Altchek, founder and CEO of Cadence, one of the nation's leading providers of remote monitoring for patients living with chronic conditions. We currently monitor patients from home across 20 states, including nearly 12,000 patients in rural and underserved communities. My written testimony details the research showing how remote monitoring delivers better clinical outcomes and lower costs.

I want to start with how remote monitoring works, and why it matters so much to patients and their families. If you have ever supported a family member following a hospitalization, you likely struggled with confusing printed instructions and a laundry list of medications. If you have helped a family member with type 2 diabetes, you know how hard it is to titrate their insulin. Many of your constituents are frustrated because clinics are too far away, they can't get in to see their doctors, and when they finally get appointments they are rushed. The vast majority of Americans are facing these challenges.

At Cadence we use technology to make it easy for patients to get better care. Patients are monitored by our clinical team from home 24/7. With easy-to-use devices, patients transmit their vitals, sharing blood pressure, heart rate, blood glucose, and weight daily. Our care team is automatically alerted when a patient needs intervention. For example, their weight increases rapidly, indicating an impending heart failure exacerbation; or their blood pressure is too low, indicating a serious infection. Cadence gets in touch proactively, quickly prescribes medications, orders labs, and schedules in-person appointments with the local physicians we work for.

This kind of swift intervention frequently prevents health issues from progressing to ER visits, hospitalizations, and even long-term disability or death. A patient with hypertension in Arkansas recently transmitted a high blood pressure of 190 early in the evening, putting them at risk for a serious event such as a stroke. Our clinicians immediately got in touch with the patient and spoke to the patient's adult child caregiver. We made a plan for a medication change, continued monitoring overnight, and avoided an ED visit. The caregiver was grateful to have Cadence there, providing peace of mind.

In our country we have the ability to significantly mitigate the impact of chronic disease, but systemically we struggle to implement relatively simple interventions. Heart failure patients' lives could be prolonged by five years on average by adherence to the right medications. However, less than 1.5 percent of these patients are even prescribed the recommended doses following hospitalizations. Our system is not set up for success. Doctors don't have fre-

quent enough vitals to make appropriate change and, even if they have the vitals, they don't have the time. Cadence's job is to fill in the gap.

Another example, the management of diabetes. The wife of one of our patients in Alabama with type 2 recently said that we saved her marriage. Before, she was constantly arguing with her husband about monitoring his blood sugar and his watching his diet. Now, every time he checks his blood glucose it transmits automatically to his doctor and Cadence. Together, we keep him accountable in real time. His A1C is decreasing for the first time in years.

Our written testimony shows that technology and an innovative care model can deliver superior outcomes at lower costs, especially in rural and underserved communities. Our data shows that remote monitoring more than pays for itself, with a 23 percent decrease in total cost.

Members of this committee, you play a critical role in determining whether modern health care becomes broadly accessible. I urge you to consider two important policy solutions.

First, please fix regional payment disparities that penalize rural communities. Reimbursement is lowest in the communities that need it most. Missouri remote monitoring pays 33 percent lower than remote monitoring in San Francisco. The old way, adjusting Medicare payments by geography, doesn't make sense in a technology-enabled system. Devices, connectivity, staff all have the same cost, regardless of location. It is an important change to an unintended policy.

Second, please ensure national payment rates stay in line with Medicare. Remote monitoring rates have declined up to 28 percent since being introduced in 2018, substantially more than Medicare rates. I encourage policymakers to look at the data and decide what kind of health care future we want for our country.

Thank you for your time. I appreciate your focus on these important issues.

[The statement of Mr. Altchek follows:]

CADENCE

Enhancing Access to Care at Home in Rural and Underserved Communities

Statement by
Chris Altchek
Founder and Chief Executive Officer
Cadence

Before the Ways and Means Committee
United States House of Representatives
March 12, 2024

Thank you, Chairman Smith, Ranking Member Neal, and distinguished members of the Committee; I am honored to speak to you today on the bipartisan topic of finding solutions to the dramatic access challenges affecting patients and families living in rural and underserved communities.

My name is Chris Altchek. I am the founder and chief executive officer of Cadence. Our expertise is in the better management of chronic disease through remote physiologic monitoring (RPM) and medication optimization, which our data show improves health outcomes while lowering the cost to the federal government of caring for Medicare beneficiaries. We provide these services to over 18,000 patients living with heart failure, hypertension and type 2 diabetes nationwide, nearly 12,000 of whom live in rural or underserved communities. In partnership with some of the most innovative health systems in the country, Cadence offers chronic disease management tools and services that give patients – including those in remote areas – 24/7 access to our care team through cutting-edge technology.

Introduction

RPM, as defined by the Centers for Medicare and Medicaid Services (CMS), involves the collection and analysis of patient physiologic data that are used to develop and manage a treatment plan related to a chronic and/or acute health illness or condition.[1] The availability of reimbursement for these services enables a team-based approach to care furnished via audio-only communication technology, which is critical for the patient population at the center of today's hearing.

I am pleased to be here discussing a strongly bipartisan priority. CMS Administrator Seema Verma led the creation of RPM services in Medicare under the leadership of President Trump. The Biden administration has been a strong champion for this care, with CMS expanding access to patients being served by rural health clinics and federally qualified health centers. CMS recently outlined plans for clinicians to use RPM to support mothers participating in the Innovation Center's upcoming Transforming Maternal Health model through remote monitoring of conditions like hypertension and diabetes.[2]

This being said, more can be done to enhance the availability of care management tools like RPM in rural and underserved communities that face limited access to primary care.[3] Cadence is at the forefront of providing digitally enabled care management services to these individuals, as a majority of our patients live in rural and undeserved areas. Adopting RPM allows clinicians to maintain closer contact with patients through the improved management of chronic conditions. With the clinical team at Cadence supporting them, primary care doctors are able to increase access to care for patients in areas suffering from clinician shortages and limited transportation options.

My testimony will focus on challenges to the adoption and scaling of technology empowering older Americans in rural and underserved communities. I recommend:

1. Addressing geographic adjustments in Medicare payment that prevent patients in rural and underserved areas from being able to access RPM for their chronic conditions. Reimbursement for RPM must cover the cost of providing these services, and currently does not meet that threshold in many rural and underserved areas.

2. Working with CMS to support an appropriate national average reimbursement rate to ensure continued patient access to high-value, evidence-driven RPM services.

3. Removal of beneficiary copays for highly effective RPM services that are demonstrating savings for the Medicare program. These services are leading to Medicare savings in the form of reduced hospital readmissions and we must remove barriers preventing access by poorer patients.

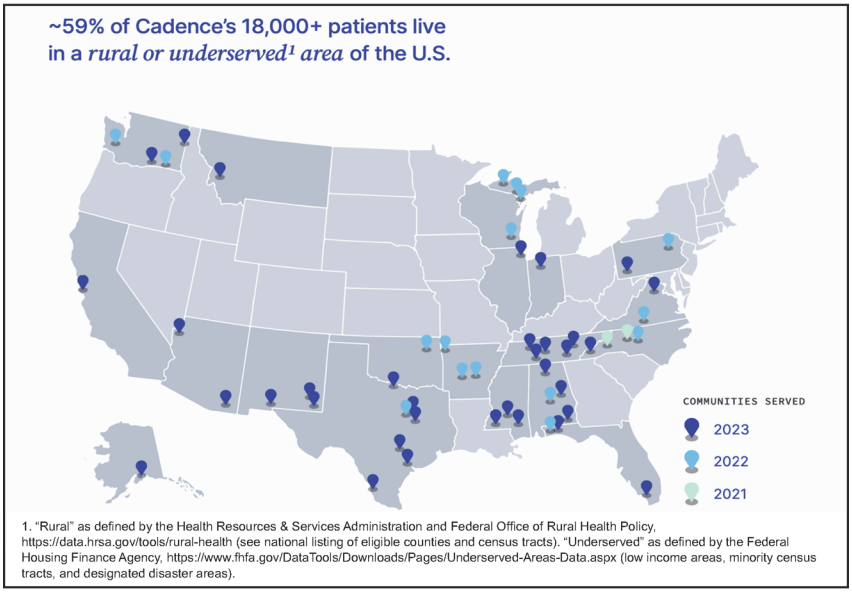
Cadence's Role in Ensuring Access to RPM Services

How does Cadence's RPM program work? A Cadence patient is on average 74 years old and is frequently hospitalized. After their local physician orders Cadence remote monitoring, the patient receives an easy-to-use, cellular-enabled device(s). There is no need for broadband, Wi-Fi, or a smartphone. They are connected and transmitting vitals seamlessly, with 24/7 support. The Cadence clinical team uses vitals data (e.g., blood pressure, heart rate, weight, blood glucose level) and the electronic medical record to adjust medications, order labs, and get patients onto the optimal care plan quickly and safely. Critically, patients can call or text anytime and get in touch with a care team member who has visibility into their vitals and medical record. Data show that Cadence remote monitoring helps patients achieve better clinical outcomes (100% increase in patients achieving goal blood pressure), avoid emergency room visits (50% decrease), and lightens the load on already overburdened primary care providers in rural and underserved areas.

Before Cadence, when seniors have challenges, they call their primary care provider and may struggle to quickly get an appointment, often ending up in the emergency department as a result. With Cadence, patients receive proactive calls when vitals present a concerning trend. Cadence clinicians work quickly to assess symptoms, make changes to medications remotely when possible, and get these patients in-person care in the appropriate setting. We make patients' health care experience dramatically better, and allow clinicians to work more efficiently.

One of our patients recently said it best: "I live in a tiny, remote, mountain community with a lot of poverty and not a single doctor. Everyone that I've told about Cadence is amazed by it. I'm very pleased, and I think my clinical team is tremendous."

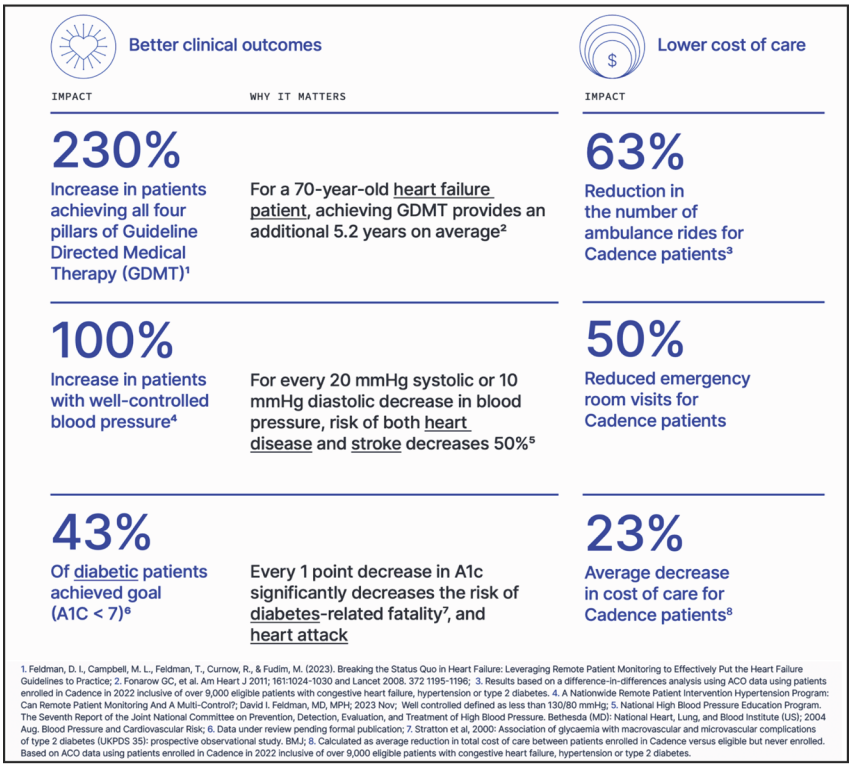
In less than two years, Cadence has deployed in 20 U.S. states and is augmenting existing primary care relationships for thousands of seniors suffering from heart failure, hypertension, and type 2 diabetes. Patients say they feel safer and more connected to their providers, with 84 percent of Cadence patients reporting their vitals at least 16 days per month. The adoption of RPM is also freeing up clinicians to see more patients through the reduction of unnecessary visits, increasing access to care in communities suffering from shortages of clinical staff.



RPM Enables Highly Coordinated Primary Care

Cadence's experience treating and managing thousands of Medicare beneficiaries alongside primary care providers has made clear that RPM is key to the future of primary care. Ninety-five percent of the physicians who order our RPM services are primary care providers who want to improve how they manage their patients' chronic conditions outside of the office visit. Patients in the Cadence program are highly engaged and report vitals daily, leading to a 23% decrease in patients' total cost of care, inclusive of the incremental costs associated with RPM services. The program also results in significant improvements in quality of care: Our data show a 230% increase in the percentage of congestive heart failure patients on all four pillars of Guideline

Directed Medical Therapy, the "cornerstone of pharmacological therapy for patients with heart failure."[4]



Our approach at Cadence has several distinctive features that directly support an integrated approach to primary care. Specifically, we have a nurse practitioner-led clinical team, a technology platform that is fully integrated with the ordering provider's electronic health record, and 24/7 support available to patients. We refer to this as "high quality RPM," in that it allows for a team-based, coordinated approach to a patient's physiologic data, safe and responsive titration of medications, and timely escalation to the appropriate care setting. These features have led to the significant positive clinical and cost-saving results in our data. Through this hands-on, tightly coordinated approach, Cadence ensures that primary care providers are able to identify and prioritize those patients who need their attention the most.

Current Literature on RPM

RPM has generated robust data in support of improved clinical outcomes for patients with chronic conditions. A randomized, controlled trial demonstrated that an RPM intervention could lead to optimization of vitals and increase in the use and dose of medical therapy for patients with heart failure, which is an accepted surrogate for hard clinical outcomes including heart failure hospitalization, morbidity, and mortality.[5] This was validated in a 2018 randomized controlled trial that studied the effect of an RPM intervention in heart failure patients and demonstrated a reduction in the percentage of days lost due to unplanned cardiovascular hospital admissions and all-cause mortality.[6] Remote monitoring and care also improves blood pressure[7] and blood glucose[8] control in hypertension and type 2 diabetes patients, respectively.

Current Medicare Payment Limits Rural Patient Access to RPM

Rural patients generally have less access to in-person primary care services than their non-rural counterparts. It is particularly important to enable RPM services for these communities. Patients on Cadence's RPM program experience meaningful clinical improvements, such as well-controlled blood pressure and achieving blood glucose goals. We encourage the Committee to prioritize policies that permit the growth of high-value, evidence-driven RPM programs.

Currently, there is a geographic variation in reimbursement for RPM, which disincentivizes the adoption of these services in rural areas where payment is generally lower. While costs for in-person care are primarily related to workforce costs and often vary geographically, the costs of furnishing some digital health services like RPM tend to be independent of the service location. Cadence uses the same model of care and clinical workforce regardless of where patients live. Identical high quality services including providing medical devices, educating the patient on the devices, monitoring physiologic data on an ongoing basis, and delivering treatment management services are reimbursed at different rates under the CMS formula. For example, RPM reimbursement in rural Missouri is 33% of what it is in San Francisco, California and 11% below the national average, even though the costs associated with this service are largely the same.

CMS' own data shows that RPM reimbursement is lower in areas where the prevalence of heart failure (HF), hypertension (HTN), and diabetes is higher:

RPM reimbursement is 33% less in rural Missouri versus San Francisco, despite higher chronic disease prevalence in rural Missouri

	Prevalence of Chronic Disease[1]			RPM Reimbursement[2]		Monthly Per Patient Reimbursement
	HF	*HTN*	*Diabetes*	*99454*	*99457*	*Ex. Claim with single units of 99454, and 99457 (i.e., one month of RPM services)*
San Francisco Cty, CA	*10%*	*51%*	*26%*	$65.66	$60.24	$126.08
Rural Missouri[3]	*15%* ***(+5%)***	*57%* ***(+6%)***	*27%* ***(+1%)***	$39.98	$44.31	$84.29 ***(-33%)***

1. CMS Chronic Conditions Public Use Database, "Chronic Conditions Prevalence, State/County 2018," https://cms-oeda.maps.arcgis.com/apps/MapSeries/index.html?appid=062934f815eb412182b3d324054ea6f0
2. Reimbursement represents Payment Amounts per the 2024 CMS Physician Fee Schedule in Place of Service 11 (Non-facility)
3. Reimbursement represents the "Missouri - Rest of State" MAC locality, which excludes counties in urban St. Louis (JEFFERSON, ST. CHARLES, ST. LOUIS AND ST. LOUIS CITY) and Kansas City (CLAY, JACKSON AND PLATTE)

Unfortunately, current RPM reimbursement is inadequate in many rural and exurban areas relative to the resources required to create and maintain an effective program that conforms to CMS' requirements. High quality RPM is labor-intensive and requires technical expertise. Costs associated with devices and our technology platform include:

- Cellular and Wi-Fi-enabled medical devices. We source and program each device to upload patient readings automatically to the Cadence platform. Additional costs associated with devices include shipping fees; ongoing cellular fees per device; in certain instances, cellular or Wi-Fi signal boosters to enable connectivity and avoid data collection disruptions for patients located in rural areas with poor cellular or internet connections; and replacement parts or devices.

- Continuous patient support. We staff care team members 24 hours a day, 7 days a week, and 365 days a year to address patient and device issues. Labor-intensive and costly around-the-clock service is necessary to ensure timely care for patients with chronic and acute conditions and avoid unnecessary trips to the emergency room. Patients have access to Cadence 24/7 via text message, phone, and email.

- Technology platform and data security. We sync patient vitals from our software to the electronic medical record to ensure this information is captured in the patient's chart. We also staff a team to improve electronic medical record integrations, which are far from standardized in the United States today, and employ full-time software engineers who design and engineer improvements, address software issues, and ensure the security of patient information.

We believe the Committee should consider legislation that implements an adjustment in Medicare by setting a floor for payment related to RPM. A logical approach to determining this floor would be to benchmark it to the average payment rate for all geographies, without the rural payment adjustment included.

Cuts to the National Average Payments Threaten to Curtail Patient Access

Moreover, national average Medicare reimbursement (non-facility) for monthly recurring RPM services has dropped so substantially since 2019 that it is increasingly challenging to cover the costs of providing effective RPM services to patients. As illustrated in the table below, cuts to these CPT codes range from 7 percent up to a staggering 28 percent, despite the increasing costs of devices and labor required to deliver RPM. Such significant decreases in a short period of time suggest a bleak outlook for patient access to these demonstrably high-value services.

	CPT Code Reimbursement[1]		Monthly Per Patient Reimbursement
	99454	*99457*	*Ex. Claim with single units of 99454, and 99457 (i.e., one month of RPM services)*
2019	$64.15	$51.54	***$115.69***
2024[2]	$46.50	$48.13	***$94.63***
% Change	*-28%*	*-7%*	***-18%***

1. Reimbursement represents the "National Payment Rate" per the 2024 CMS Physician Fee Schedule in Place of Service 11 (Non-facility)
2. 2024 Reimbursement is accurate as of 3/1/24, prior to the impact of the Consolidated Appropriations Act, 2024 (H.R. 4366)

The Committee should take steps to ensure that Medicare appropriately reimburses the clinical team's work involved in maintaining longitudinal relationships, providing personalized care, and coordinating across the care team via RPM. These are high-impact services for both patient outcomes and costs that should be valued accordingly.

Beyond Medicare, reimbursement for RPM services by Medicaid and commercial payors is uneven. The lack of alignment across Medicare, Medicaid, and commercial plans regarding coverage of RPM services makes it difficult for physicians to reliably provide these services and for patients to know what services are accessible to them. While a majority of state Medicaid programs cover some form of remote monitoring services, many do not cover all of the RPM codes and reimbursement is often significantly lower than Medicare's rates.[9] Commercial coverage can also entail restrictions that are not present under Medicare, such as only covering RPM for particular disease states, even if the clinical efficacy of RPM is proven for other conditions.

As we can generally expect to see private payors follow Medicare's lead, I encourage Congress to take action to halt the precipitous declines in reimbursement for RPM services we have experienced over the past five years.

Removal of Copays on RPM Services

I also support existing Congressional efforts to eliminate the 20 percent copay for RPM services for at least a two-year period in order to study the effects on patient outcomes and cost savings to Medicare.[10] The financial burden of the copay obligation is a top reason patients disenroll from Cadence's RPM program, even as these patients are seeing improvements to their health and appreciate the support of a 24/7 remote care team. Such legislation would be an important step toward improving health outcomes in rural and underserved communities, in addition to reducing travel times for rural patients and lessening the burden on health care providers.

Conclusion

In closing, RPM plays a critical role in providing older Americans in rural and underserved communities with access to world-class care for chronic disease. I appreciate the Committee's dedication to enhancing health care access for this patient population. I thank Chairman Smith, Ranking Member Neal, and members of the Committee for allowing me to appear before you today to discuss this critical topic in health care.

[1] 85 FR 84472, at 84542 (Dec. 28, 2020), https://www.federalregister.gov/d/2020-26815.

[2] CMS, Transforming Maternal Health Model, https://www.cms.gov/priorities/innovation/innovation-models/transforming-maternal-health-tmah-model (accessed Mar. 2024).

[3] Petterson, S. M., et al., Unequal distribution of the US primary care workforce. American family physician, 87(11) (2013), https://pubmed.ncbi.nlm.nih.gov/23939507/.

[4] Patel J., et. al., Guideline-Directed Medical Therapy for the Treatment of Heart Failure with Reduced Ejection Fraction (2023), https://pubmed.ncbi.nlm.nih.gov/37254024/.

[5] Desai A. S., et al., Remote Optimization of Guideline-Directed Medical Therapy in Patients With Heart Failure With Reduced Ejection Fraction. JAMA Cardiol. 2020 Dec. 1;5(12):1430-1434. DOI: 10.1001/jamacardio.2020.3757.

[6] Koehler F., et al., Efficacy of telemedical interventional management in patients with heart failure (TIM-HF2): a randomised, controlled, parallel-group, unmasked trial. Lancet. 2018 Sept. 22;392(10152):1047-1057. DOI: 10.1016/S0140-6736(18)31880-4.

[7] Blood A. J., et al., Results of a Remotely Delivered Hypertension and Lipid Program in More Than 10 000 Patients Across a Diverse Health Care Network. JAMA Cardiol. 2023 Jan. 1;8(1):12-21. DOI: 10.1001/jamacardio.2022.4018.

[8] Lee P. A., et al., The impact of telehealth remote patient monitoring on glycemic control in type 2 diabetes: a systematic review and meta-analysis of systematic reviews of randomised controlled trials. BMC Health Serv Res. 2018 Jun. 26;18(1):495. DOI: 10.1186/s12913-018-3274-8.

[9] Center for Connected Health Policy, Remote Patient Monitoring (accessed Mar. 2024), https://www.cchpca.org/topic/remote-patient-monitoring/.

[10] See RPM Cost Sharing Elimination Study Act of 2023, https://cherfilus-mccormick.house.gov/sites/evo-subsites/cherfilus-mccormick.house.gov/files/evo-media-document/rpm-bill.pdf.

Chairman SMITH. Thank you.
Dr. Mehrotra, you are now recognized.

STATEMENT OF ATEEV MEHROTRA, PROFESSOR OF HEALTH CARE POLICY AND MEDICINE AT HARVARD MEDICAL SCHOOL AND HOSPITALIST AT BETH ISRAEL DEACONESS MEDICAL CENTER

Dr. MEHROTRA. Thank you, Chairman Smith, Ranking Member Neal, and other distinguished members of the committee. I am honored to testify before you today on a topic of such importance to Americans and their health.

I conduct research on telehealth and remote patient monitoring because I am excited about how these technologies can address the complaint I often hear from my patients, and what I am sure you hear from your constituents, that Americans across this nation often have difficulty accessing care. And these barriers are often larger among those who live in rural and underserved communities. In my testimony today I will describe how emerging research may inform potential legislation.

My first point is that telemedicine has resulted in a more modest change in health care delivery than initially envisioned. At the start of the pandemic, some contemplated whether the unprecedented growth in video and telephone visits was the beginning of a new normal, one with telemedicine visits as a core component of how patients receive care. The reality has been more of a modest change in the most clinical areas, and the number of telemedicine visits in the Medicare program continues to fall.

In surveys, interviews, patients and physicians greatly value the availability of video visits and want them to remain an option. However, both have questioned the quality of care in a video visit, and specifically the inability to conduct a physical exam.

The second point is telemedicine does increase spending, but modestly. The key impediment to permanent expansion of telemedicine has been the possibility that telemedicine will drive up spending. Telemedicine's ability to make care convenient and more accessible, the key to its enormous potential to improve health, may also be its Achilles heel.

In my own research we find that greater telemedicine use does lead to more visits, and this is associated with small improvements in chronic disease medication adherence and fewer emergency department visits. However, these improvements do come at a cost. We estimate that greater telemedicine use is associated with a one to two percent increase in health care spending per Medicare beneficiary per year, and our results are generally consistent with other research, including those from MedPAC.

Based on these findings, I recommend that the Congress permanently eliminate site location requirements and allow video visits for all conditions at any site. While telemedicine does increase spending, the increase is modest and is associated with some improvements in access and quality. And perhaps most importantly, patients and clinicians want telemedicine to remain an option. And given this emerging evidence, it is hard to justify stopping coverage.

Invariably, areas will emerge where we see both over-use as well as outright fraud. But I believe these areas could be addressed selectively. For example, Medicare could address concerns of fraud by requiring in-person visits if a physician wants to order specific high-cost tests.

My third point is that telemedicine visits should be paid less than in-person visits. Payments for care in the Medicare program are based on the time a clinician takes to provide the care and the associated space, staff, and equipment. If something costs less, it should be paid less. While it does require some overhead, telehealth visits do not require the same practice expenses.

Some clinicians have objected. They argue that their practice expenses have remained the same because they provide both in-person visits and telehealth visits. I disagree. I do not think Medicare should cross-subsidize in-person visits with telehealth because it will create distortions in care. It will give virtual-only companies an unnecessary competitive advantage. It will also incentivize clinicians to give up their physical practice. Already we see that roughly 13 percent of mental health specialists have given up their physical office and gone virtual-only.

And lastly, remote patient monitoring is effective, but its value can be improved. Remote patient monitoring, like others have said, is a promising clinical model that may improve the care for many Americans with chronic illness, and use is growing rapidly in the United States. And consistent with others, in my own research we find that among patients with high blood pressure it leads to greater adherence to medications and fewer related hospitalizations and emergency department visits. And another strength is that we find that it is more likely to be used by underserved communities.

However, and contrary to what others have said, we find that remote patient monitoring increases health care spending in the Medicare program. There are several ways we believe we can improve the value of remote patient monitoring. For example, instead of the current policy of unlimited reimbursement, I believe Medicare should limit the time period, given that most of the benefit is in the first couple of months.

Again, I thank Chairman Smith, Ranking Member Neal, and distinguished members of the committee for allowing me to appear before you today, and I look forward to your questions.

[The statement of Dr. Mehrotra follows:]

Next Steps in Payment and Regulatory Policy for Telehealth

Statement by
Ateev Mehrotra MD
Professor of Health Policy and Medicine
Harvard Medical School

Before the Committee on Ways & Means
United States House of Representatives
March 12, 2024

Thank you, Chairman Smith, Ranking Member Neal, and distinguished members of the committee; I am honored to have been invited to testify before you on a topic of such critical importance to Americans and their health.

My name is Dr. Ateev Mehrotra. I am a physician at the Beth Israel Deaconess Medical Center and a Professor at Harvard Medical School. My research focuses on the impact of telehealth. Specifically, how do various forms of telehealth impact quality, spending, and people's ability to access care, particularly in rural and underserved communities? I have studied a wide range of clinical applications of telehealth, including stroke, mental illness, substance use disorders, contraception, and acute respiratory illness. I do this research because I hope telehealth can help address the common complaint I hear as a physician and what I am sure you hear from your constituents: that people across this nation often have difficulty accessing timely care.

INTRODUCTION

The rapid adoption of telemedicine visits (audio-video and audio-only) early in the pandemic was dizzying, with telemedicine visits accounting for 42% of Medicare outpatient visits in April-May 2020.[1] Clinical changes that I would have expected to take a decade occurred within weeks. Most federal pandemic-era telehealth policies have remained temporary and have been extended numerous times by Congress. Currently, many are scheduled to expire at the end of 2024. Implicit or explicit in the legislation authorizing these extensions is that more research is needed to dictate permanent regulations. As I describe below, some of that evidence is starting to emerge, although there remain many gaps in our understanding of the impact of this rapid shift in care.

Some have contemplated whether the unprecedented rates of telemedicine use during the COVID-19 pandemic were the beginning of a new normal — one with telemedicine as a core component of how patients receive care. As of today, there has been more of a modest change in most clinical areas than a paradigm shift.[2] The number of telehealth visits per month in the United States continues to fall since its peak in April 2020 and today represents roughly 5% of all outpatient visits in Medicare.

In surveys and interviews, patients and physicians have greatly valued the availability of telehealth and want it to remain an option in the future.[3] However, both patients and physicians have questioned the quality of care provided in a telehealth

visit, specifically due to the inability to conduct a full physical exam and key tests (e.g., electrocardiograms).[4] Many patients prefer in-person visits.[5]

In contrast to the rise and subsequent fall of telemedicine visits, other forms of telehealth that emerged during the pandemic have had a more sustained impact. Most notably, remote patient monitoring use has continued to grow over the last four years.[6] Other forms of telehealth that have received less attention include asynchronous visits (eVisits), telehealth-facilitated consultations between clinicians (eConsults), and simple messages from patients asking their clinicians for advice. Across over 300 health systems that use the Epic electronic health record, there was a 57% increase from early 2020 in the number of messages patients submit daily via patient portals asking for medical advice.[7]

I commend the committee for focusing on the impact of telehealth on rural communities and the underserved. There are persistent disparities in access, utilization of care, and outcomes between rural and urban residents. There is the potential for these telehealth tools to bridge these gaps and make care more equitable. However, I am also mindful that, if deployed poorly, greater use of telehealth may increase disparities. In one study, we found that, despite the growing of telehealth in rural communities, the rural-urban gap in the treatment of mental health treatment became larger.[8]

My testimony will focus on the future of payment policy and regulations for telehealth. I began by describing key principles that I believe should drive policy and then discussing the following seven issues related to payment and regulation and offer policy recommendations for each:

1. Permanent expansion of telehealth coverage for all Medicare beneficiaries
2. Whether telehealth visits should be paid at the same rate as in-person visits (payment parity)
3. Access to telehealth and the role of audio-only visits.
4. In-person visit requirements before a telemental health visit
5. Paying for remote patient monitoring
6. Physician licensure in the context of out-of-state telehealth visits
7. Telehealth payment models

KEY PRINCIPLES FOR TELEHEALTH POLICY

There is a common notion that telehealth can reduce healthcare spending. I am skeptical of these claims. Like almost all other innovations in healthcare, such as new drugs or surgical procedures, telehealth likely increases spending. Instead of the question of whether telehealth saves money, policymakers should formulate their telehealth policy decisions through the lens of *value*. This is the first key principle. In the case of telehealth, value is how many dollars we spend to improve care outcomes and access. Improvements in access could decrease travel time, disruption to lives, and the need for childcare. Under the value framework, the questions are: What are the high-value applications of telehealth? And how can policies encourage higher-value applications of telehealth and discourage lower-value applications of telehealth?

Value is dictated by the condition treated (for example, common cold vs. stroke) and the patient receiving care. Consider two patients with depression who can participate in a telehealth visit. One lives in rural Alaska without access to local clinicians and substantial transportation barriers. Telehealth could be the only way he can access care and improve his condition. The second patient lives in Anchorage, her depression is well controlled, she sees her psychiatrist every month, and she is on the right medications. There is minimal value in an additional telehealth visit every two weeks for her depression.

Many of the policies that have been considered or implemented by Congress (for example, targeted expansions of telehealth by condition and limitations on which patients can receive telehealth) try to prioritize higher-value applications of telehealth while continuing to restrict applications with uncertain value. For example, implicit in Congress's prior focus on telehealth for rural communities is that rural residents have more difficulty accessing care. Implicit in the expansion of telehealth for mental illness treatment is that mental illness is undertreated in the United States. The hope is that targeted expansions result in substantial quality improvements at a reasonable cost.

It is important to acknowledge that all such policies are inherently crude. Many patients not targeted by these policies have difficulty accessing care. Fundamentally, using billing rules and regulations in the fee-for-service system to determine when one form of telehealth is allowed and another is not allowed is daunting — clinicians and patients will quickly point out circumstances where the payment rules do not make sense. The growth of telehealth has accelerated the need to shift to other forms of payment.[9] This is a topic I touch upon below.

The second principle is that we should try to *avoid one-size-fits-all telehealth policies* — just as there can be no single coverage policy for all prescription drugs. In the same way, different drugs yield different outcomes, telehealth's benefits will vary across clinical conditions, different forms of telehealth, and different providers. For example, telehealth for treating stroke could save lives, while telehealth visits for the common cold have little clinical benefit.

Another critical distinction in telehealth policy is the type of clinician. Many clinicians have switched to a telehealth-only model working independently or for a growing number of telehealth companies. For example, 13% of mental health specialists have closed their in-person clinic and only see patients via telemedicine.[10] While telehealth-only providers may improve access and some have introduced many innovative models, their growing importance has raised new issues. They have lower overhead costs than "brick and mortar" providers because they do not have to pay for office space and equipment. Also, many of the new telehealth companies are growing rapidly through venture capital funding. This pressure to grow rapidly may have been one driver of a recent scandal where a direct-to-consumer telehealth company was accused of overprescribing stimulant medications.[11] It is unclear whether telehealth-only providers should be regulated and reimbursed differently.

The third principle is that we want to *limit the administrative burden*. Administrative burden frustrates patients and clinicians and drives up spending. Already, clinicians sometimes struggle to bill and document telehealth visits correctly because of the complexities of current rules.[12] For example, which of the many billing modifiers should they use for a given telehealth visit? Similarly, physicians caring for patients across many states have difficulty navigating the labyrinth of current state licensure. Whenever possible, payment models and regulations for telehealth should be simplified.

SEVEN ISSUES RELATED TO PAYMENT AND REGULATION

1. **Permanent expansion of telehealth coverage for all Medicare beneficiaries**

Concern that telehealth will drive up healthcare costs is a key impediment to its permanent expansion. Consistent with others, including the Congressional Budget Office,[13] I have expressed concern that greater telehealth use will increase spending. The worry is that in some circumstances, telehealth is *too convenient* and may encourage greater use of care such that telehealth visits may largely be additive to the healthcare system. In other words, telehealth's ability to make care convenient and more accessible — the key to its enormous potential to improve the health of many patients — may also be its Achilles' heel.

After several years, evidence is beginning to emerge on the impact of greater use of telehealth. In our work, we took advantage of variations in uptake across large health systems to understand the impact of telehealth use.[14] For various reasons, including the type of electronic health record, health system leadership, and local policy, some health systems

adopted telehealth to a greater degree than others. We compared patients receiving care at health systems that used more telehealth during the COVID-19 pandemic to those that relied more on in-person services. The difference in telehealth use in 2020 was substantial – patients assigned to the highest telemedicine adoption health systems received 27% of their visits via telemedicine compared to 10% in the lowest telemedicine adoption. Though telemedicine use fell through December 2022, patients at high telemedicine health systems continued to receive more telemedicine through the end of 2022.

In 2021-2022, we found a relative increase of 2.2% in visits per patient per year between patients in the highest and lowest telehealth use health systems. Most of these visits (83%) substituted for in-person visits. The relative increase in visits was larger among lower-income, non-white patients. Patients receiving care from higher telehealth health systems also had small improvements in chronic disease medication adherence and decreased ED visits. However, these changes accompanied a $248 (1.6%) increase in healthcare spending per capita.

Our results showing increases in visits, small increases in spending, and modest improvements in quality are qualitatively consistent with other recent work. An analysis for the Medicare Payment Advisory Commission found that geographic areas with higher telehealth uptake through 2021 had a 3% relative increase in total clinical encounters and a spending increase of $165 per capita.[15] A 2021 study in Ontario found that greater physician telehealth uptake was associated with small decreases in ED visits.[16] Another analysis focused on telehealth for mental illness found that greater telehealth use was associated with more total visits (in-person plus telehealth) without substantial improvement in quality metrics.[17] Our results are also consistent with Congressional Budget Office modeling that telehealth expansions for mental illness will increase spending because of projected increases in total visits.[18]

Though we observe an increase in outpatient visit utilization, the increases we and others have documented are relatively small. Several factors may explain this. Clinicians may have limited capacity to provide additional visits. Alternatively, there may have been limited demand from patients. As noted above, patients have worried that the quality of telehealth visits is lower than in-person visits.[19]

It is important to acknowledge the limitations of these studies. We use data through 2022, when there were still ongoing waves of COVID-19 illness, which may have impacted healthcare-seeking behavior. One must be cautious in extrapolating results from the care patterns during the pandemic to those we will observe after the pandemic. The effects of telehealth on quality and spending could change as technology improves, health systems optimize telehealth services or patient demand changes. The results may not translate to virtual-only companies, and these broad-based evaluations do not capture the quality outcomes specific to a clinical area. Therefore, moving forward, it will be important to continue monitoring telehealth's impact on quality and spending in different clinical areas.

Policy recommendation: Permanently eliminate site-location requirements and allow video visits for all conditions at any site to any Medicare beneficiary in the United States.

My recommendation tries to balance the principles I described above. While telehealth does not reduce healthcare spending, the increase in spending is modest, and the research has highlighted that greater telehealth can result in small improvements in access and quality. Perhaps most importantly, patients and clinicians want telehealth to remain an option, and policymakers will find it difficult to "take away" telehealth. Limiting telehealth expansions to some conditions or patients adds administrative burden (for example, navigating different modifier codes). Finally, almost four years after the pandemic's start, it is reasonable to signal to clinicians that telehealth payments are here to stay so they can make investments in telehealth with more certainty.

Policy recommendation: Permanently allow Federally Qualified Health Centers and Rural Health Clinics clinicians to provide telehealth visits beyond mental health visits as "distant" clinicians

I would also permanently allow Federally Qualified Health Centers and Rural Health Clinics clinicians to provide telehealth visits beyond mental health visits as "distant" clinicians, enabling them to provide telemedicine care to patients in their homes. These clinics often treat patient populations with greater difficulties accessing care; therefore, their telehealth visits will likely be of higher value.

Invariably, areas will emerge where we observe overuse or low-value telehealth use. But those areas could be addressed on a case-by-case basis by Medicare. For example, Medicare could address concerns of fraud or overuse by requiring in-person visits if a physician wants to order specific high-cost tests.

Given the rapid pace of change in telehealth, I believe it is critical to give Medicare as much flexibility as possible in adapting telehealth policy. As noted above, I am both excited and concerned about the emergence of private telehealth-only companies. Unfortunately, there is a dearth of data on their impact. To better track the care they provide, Medicare should be able to require clinicians to report if they have any corporate affiliations and Medicare should have the ability to exclude specific companies, they believe provide low-value care.

2. Whether telehealth visits should be paid at the same rate as in-person visits (payment parity)

Payments for office visits in the Medicare system are based on the time a physician or other clinician takes to provide care and the overhead to support the space, staff, and equipment necessary to provide that visit. For a common office visit (CPT 99213), the payment is roughly half for physician time and half for these practice expenses. While it does require some overhead, telehealth visits do not require the same practice expenses as in-person visits. Physicians also believe that telehealth visits cost less than in-person visits.[20]

Policy recommendation: Payment for telehealth visits should be less than in-person visits

Given the lower cost structure, I recommend that telehealth visits be paid less than in-person visits. Some clinicians have objected. They argue that their practice expenses have remained the same because they provide both in-person and telehealth visits and therefore must maintain the same staff and resources. This argument does not convince me. I do not think Medicare should cross-subsidize in-person visits with telehealth visits because it will create distortions in the market. Paying the same amount for telehealth visits will also give virtual-only companies a competitive advantage and incentivize brick-and-mortar clinicians to give up their practice.

The correct difference in payment between a telehealth visit and an in-person visit is unclear. Currently, Medicare reimburses for a telehealth visit ~25% less than an in-person visit.[21] While this is a reasonable starting place, this difference may need to be adjusted as Medicare receives more data on the practice expenses necessary to provide telehealth visits.

3. Access to telehealth visits and the role of audio-only visits.

Our research, and the research of others, has found that within communities both rural and underserved patients are less likely to receive audio-only and video telehealth visits.[22] Patients with limited English proficiency and those with visual and hearing impairments may also have difficulty accessing telehealth.

A related issue is the role of audio-only visits. Though it is unclear exactly what fraction of telehealth visits are audio-only,[23] they appear to be quite common. Audio-only visits may be particularly important for underserved patients and safety-net clinics.[24] In a study on digital access, we found the proportion of patients with access to the necessary technology for a video visit was lower among those with a high school education or less, who were Black or Hispanic,

received Medicaid, or who had a disability.[25] Many policymakers have mandated coverage of audio-only visits to ensure all people have access to telehealth. For example, Arkansas, Florida, Kentucky, Vermont, and Washington have all passed legislation ensuring access to audio-only care for all residents or those with Medicaid.[26] However, there are also concerns from physicians and policymakers that audio-only care may lead to inferior care. Though there is limited data on the quality of audio-only telehealth visits, in one survey of clinicians who treat substance use disorder, 70% perceived that their patients received higher-quality care via video than audio-only visits.[27]

One assumption is that clinicians turn to audio-only visits due to patient preference. However, growing evidence shows audio-only visits may also be driven by provider preference. Many clinicians do not offer video visits to all their patients, and they are less likely to be offered to underserved patients.[28] There is substantial variation in video telemedicine use among Federally Qualified Health Centers. This difference appears to be driven by their information technology platforms and what investments were made in helping patients address barriers to obtaining video visits.[29]

Policy recommendation: Mandate that all patients are offered video visits and pay for audio-only telehealth visits for a time-limited period, such as two to three years

It is important all patients are offered video visits. While I recognize telephone calls may be currently important for some rural and underserved populations, I am concerned about a future with a two-tiered system where the poor receive phone calls and the wealthy have video visits. Although a phone call may be sufficient in many cases, I worry that, on average, phone calls may not lead to the same level of care. I also recommend Medicare require clinicians providing an audio-only visit to attest that they offered the patient a video visit and that their clinic provides resources to patients who face barriers to video visits. I hope limiting payment for a short period and requiring this attestation will spur the necessary investments in support at clinics so that all Americans can receive a video visit. It will also create an opportunity for more research on what impact audio-only visits have on quality, spending, and access.

4. In-person visit requirements before a telemental health visit

At the end of 2020, Congress permanently expanded coverage of telemental health in Medicare but required that an individual have an in-person visit within six months before the first telemental health visit. Many mental health clinicians expressed concerns that there was no evidence of clinical benefit for this requirement, and it would create an unnecessary barrier to care. In December 2022, Congress passed legislation delaying the in-person requirement until January 2025.

To better understand what impact this rule may have on care in the future, we examined the care of Medicare fee-for-service beneficiaries. Of the more than 800,000 first telemental health visits in 2022, only 19% were preceded by an in-person visit with that clinician.[30] Our results highlight that such a new requirement would require a substantial change in current practice. It could also imply that clinicians do not perceive in-person visits within six months as clinically necessary.

Policy recommendation: Remove the requirement for in-person visits before mental health visits

In-person visit requirements limit the ability of telehealth to expand access to mental health services for patients who live far from any mental health clinician and, therefore, cannot have in-person care.

5. Paying for remote patient monitoring

Remote patient monitoring is a promising clinical model that may improve the care of many Americans with chronic illness. Consistent with others, in our own research, we find it leads to greater adherence to medications, more adjustments to medication regimens, and fewer hypertension-related hospitalizations and emergency department visits.[31]

In contrast to other forms of telehealth, we find it is more likely to be used by racial and ethnic minorities and lower income patients.

Consistent with other forms of digital health, it also leads to increased spending. One driver of the increased healthcare spending was that many patients who began using remote patient monitoring were already doing well with their chronic illness. Another driver is that the benefits of remote patient monitoring are largely seen in the first few months of use, but many patients continue on remote patient monitoring for more than a year. A third driver was that remote patient monitoring did not substitute for office visits but was used as a complement.

Policy recommendation: Improve the value of remote patient monitoring through changes in the payment model

Consistent with the recommendations of others, I believe there are several ways we can improve the value of remote patient monitoring. Instead of the current policy of unlimited reimbursement, Medicare should limit reimbursement to 6 months. Medicare should limit reimbursement to focus care on patients with poor baseline adherence or use other techniques to incentivize its use among patients most likely to benefit. Finally, payment guidelines should be clarified so that clinicians understand that the remote patient monitoring payment encompasses many of the encounters for medication adjustment. If remote patient monitoring is limited to fewer patients, reimbursement should be increased given the substantial setup costs associated with such a program.

6. Physician licensure in the context of out-of-state telehealth visits

The COVID-19 pandemic prompted federal and state governments to relax licensure requirements temporarily to facilitate out-of-state physicians' care. During the early-pandemic period (through mid-2021), there was substantial use of out-of-state telehealth.[32] Among all Medicare beneficiaries with a telemedicine visit, 5% had an out-of-state telemedicine visit. In most cases, this was a continuation of an established relationship. Out-of-state telemedicine use was greatest for some conditions, such as cancer, among people who lived near a state border and in more rural states such as Montana and South Dakota. Most of these temporary regulations have now expired.

This return to pre-pandemic policy is not limited to video visits. Follow-up phone calls are also victims of this return to pre-pandemic licensure practice. Some lawyers have interpreted that a follow-up phone call constitutes the "practice of medicine" and must be limited to patients in a state where the physician is licensed. For example, the governing code in Texas defines practicing medicine as "diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method" and notes that any "person who is physically located in another jurisdiction but who, through the use of any medium, including an electronic medium, performs an act that is part of a patient care service initiated in this state…that would affect the diagnosis or treatment of the patient, is considered to be engaged in the practice of medicine."[33] Texas is not unique; similar definitions and rules exist in other states. Such rules can create issues for a patient seeking clinical advice from a physician in their home state while traveling to another state.

These geographic limitations of telehealth visits have created substantial frustration. Patients wonder why driving across a state border results in better care. For many video telehealth visits, patients sit in cars or coffee shops on smartphones, searching for good WiFi and sharing tips about the best parking lots just across the state border.[34] And many patients simply stopped following up with their out-of-state physicians.[35]

Unfortunately, reforms such as the Interstate Medical Licensure Compact, a process for making it easier for physicians to get a full license in multiple states, or the use of special telehealth licenses have had limited benefits. Expanding the use of licensure exceptions would be more helpful.[36] Many states have already incorporated exceptions to their licensure requirements. For example, Arizona allows a physician licensed in another state to provide telehealth to a patient in

Arizona "[t]o provide after-care specifically related to a medical procedure that was delivered to a person in another state."

Using these exceptions is relatively simple for a physician. A physician only needs to be aware of the limitations of exceptions and that one cannot initiate a physician-patient relationship using an exception. From a patient perspective, such exceptions would allow most patients to use telehealth when needed. A student who is away at college can still see their psychiatrist in their home state. Patients traveling for work can keep in touch with their primary care physician regardless of where they are.

Policy recommendation: Implement a narrow exception to state licensure allowing any physician to provide telehealth across state lines if they have an established prior relationship with that patient

I am supportive of federal efforts such as the Licensure Portability Grant Program to support state efforts to increase telemedicine across state lines. The ideal solution would be for federal legislation to create a narrow exception to state licensure. Under this exception any physician could provide telehealth across state lines if they have an established prior relationship with that patient. The advantage of federal legislation is that it creates a clear set of rules nationwide. While many states have implemented similar exceptions, the language is not always consistent, and physicians must carefully track the specific rules in the state where their patient is currently located. Creating this type of narrow exception for licensure is consistent with prior federal licensure legislation, such as the Sports Medicine Licensure Clarity Act[37] and the VA MISSION Act.[38]

There is also wide support for the use of exceptions. The American Medical Association supports the need for greater use of exceptions for out-of-state telemedicine follow-up care. The Federation of State Medical Boards believes there is a need for exceptions that "permit the practice of medicine across state lines without the need for licensure in the jurisdictions where the patient is located. Again, these licensure exceptions would only be focused on established medical problems or ongoing workups and care plans."[39]

7. Telehealth payment models

In contrast to the typical fee-for-service system, payments for remote patient monitoring are paid via a monthly bundled payment instead of fee-for-service payments. The bundled payments include payments for data transfer costs and all communication between clinicians and patients in the month. Similar payment innovation is needed for other forms of telehealth, such as portal messages.[40] The number of portal messages has surged during the pandemic, and clinicians, particularly primary care physicians, are frustrated because they spend substantial time at night answering these messages largely without reimbursement.[41] The fee-for-service system is poorly suited for frequent but short interactions, such as short phone calls or portal messages. When the units become smaller and smaller (e.g., it may take a clinician only 2 minutes to respond to a portal message), the estimated $20 of administrative costs required to submit a bill for a single patient encounter may not be worth it.

Policy recommendation: Give Medicare flexibility to create payment models that use partial capitation or bundled payments to pay for telehealth applications such as portal messages

I encourage legislation giving Medicare as much flexibility as possible to create payment models that use partial capitation or bundled payments to pay for telehealth applications such as portal messages. Such alternative payment models give clinicians the flexibility to use the full range of telemedicine tools (portal messages, video visits, eVisits, phone calls, eConsults, telemonitoring) best suited for an individual patient and clinical scenario and avoid the administrative burden of billing for each encounter.

SUMMARY OF POLICY RECOMMENDATIONS

To summarize, my policy recommendations are:

- Permanently eliminate site-location requirements and allow for video visits for all conditions for all Medicare beneficiaries.
- Pay for telehealth visits at a lower rate than in-person visits, avoiding telehealth parity.
- Mandate that all patients are offered video visits and pay for audio-only telehealth visits for a time-limited period, such as two to three years
- Remove in-person visit requirements before mental health visits.
- Reform payments for remote patient monitoring to increase the value of the care provided.
- Introduce selective exceptions to state licensure that allow patients to get care from any clinician with whom they have an established relationship.
- Encourage innovation in payment models for telehealth that use bundled payments or partial capitation.

I acknowledge that the coverage decisions and payment choices I recommend are not perfect. They will deter some effective forms of telehealth and may add some administrative burden. Also, telehealth use is rapidly changing, and policy must adapt accordingly. However, I believe they represent the best way to encourage high-value applications of telehealth and encourage a necessary transformation of our healthcare system.

Again, I thank Chairman Smith, Ranking Member Neal, and members of the committee for allowing me to appear before you today to discuss this critical topic in health care.

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Chairman SMITH. I want to thank you all for your testimony. We will now proceed to the question-and-answer session.

Mrs. Maddux, it looks like you have some helpers behind you, too. Do you want to introduce them?

Mrs. MADDUX. Sure. My daughter is Emmy. She is 12. And my son is Kai. He is seven.

[Applause.]

Chairman SMITH. So your personal story of living with ESRD and experience with home dialysis speaks to the importance of expanding care-at-home options, particularly for kidney patients in rural communities who are more likely to utilize and benefit from home dialysis.

What has been the impact of this option on your quality of life and your role as a working mother?

And what, if any, improvements would you like to see to enhance the quality and convenience of care at home?

Mrs. MADDUX. Sure, thank you for that question.

In terms of the impact to my quality of life, I think I mentioned earlier that, from a physical perspective, the frequency of your treatments, of your dialysis treatments, have a direct correlation to how you feel. So I noticed immediately when I started doing that first week of home dialysis training that having the consecutive treatments, the impact on how it is on your heart and just how it hits your system, it is just easier. So I felt better, I had more energy right away.

And then, when it comes to just the dietary restrictions and, like, the fluid restrictions that I was dealing with at that time, I felt that I was able to have more control over what I was eating, or when I wanted to eat, and how much I was able to drink because of the frequency of the treatments.

In terms of it being at home, I have a lot of different appointments that I have to go to. I am listed at several—or almost three different transplant centers. And so that in itself requires a lot of follow-up doctor's visits. I spend a lot of time going back and forth to the doctor. The fact that I can have one thing where I am eliminating a trip to a specific office that might be two or three hours away, or a half-an-hour away, whatever the case may be, it makes it an opportunity for there to be more time that I can spend at home, taking care of my family, doing work, or essentially doing things that I want to do.

Chairman SMITH. Thank you.

The Hospital at Home has shown many benefits in its short time as a program, from reduced health care costs to better patient outcomes and lower hospital readmissions. Mr. Underhill, you have received hospital-level care both in facilities and now in your home through this new program. In your testimony you spoke of the benefits of recovering from your serious condition at home: better sleep, home cooking. Please describe the impact receiving Hospital at Home had on your family and friends to see you heal in your own home.

Mr. UNDERHILL. Oh, because of the COVID being at its peak then they could not have visited me in the hospital at all, so I would have been on my own.

And if you have tried to sleep in a hospital recently, you know the beeping, the constant beeping that you can't figure out what it is for, I didn't have that at home. I also had my own bed clothes instead of the disturbing garment that you are issued. [Laughter.]

Mr. UNDERHILL. All around, just having my own books and being able to get a glass of water and make it to the refrigerator made such a difference.

I also just felt safer and less a burden. Nobody wants to be a burden on folks. Being at home I was on my own and feeling better every day. So just that safety, the comfort, the comfort of home and the comfort of friends and family, that made a huge difference. And there is just nothing like it.

Chairman SMITH. Thank you.

Dr. Starr, there is tremendous hope and expectation for an ever-expanding scope of health-care-at-home services, with high levels of satisfaction for both patients and providers. While most folks are probably familiar with telehealth calls with their doctor, could you please share with us the full scope of telehealth and health-at-home services you are seeing today across the country?

And additionally, can you describe how audio-only telehealth is utilized by the rural patients you serve?

Dr. STARR. Yes, thank you for that question.

So we are seeing a scope that really encompasses the entire patient journey, from both preventative care to care of chronic conditions to, really, you know, acutely ill patients in an intensive care unit at a small hospital that would otherwise need to be transferred. And being able to impact patients throughout that whole spectrum is really where we see so much value.

We approach our telehealth programs, really, from a value based perspective, where our goal is to prevent the need for transfer, to keep patients in their communities where they will heal better, and the—even keep a lot of that revenue local to support those smaller hospitals.

In terms of the audio-only care, there are times where what you need to do is get a history from a patient. Our most valuable diagnostic tool is still a history, like, talking to the patient, understanding how they feel. And that can be done over the phone if there are no other options, and can be a very significant way of collecting the information we need to help manage the patient.

Chairman SMITH. Thank you. Advanced technologies are aiding today's health care providers in breaking through a broken status quo in the delivery of care to rural and underserved communities, improving patient outcomes and lowering health care costs.

Mr. Altchek, from your perspective as an innovator in this field, where do you see the biggest impact, the most positive disruptions occurring when it comes to improving care in rural communities?

And how specifically does ensuring fair reimbursement for services across varying geographics play a huge part in that?

Mr. ALTCHEK. Thank you, Chairman Smith.

Rural and underserved communities disproportionately face the impacts of chronic disease crisis in America, and we have an opportunity as a country to do a much better job of being much more proactive, supporting patients and keeping them out of the hospital to begin with.

The technology today has advanced to a point where we can cover—you know, of the members of this committee, we have 13—we have patients in 13 states, and we can do so in a way where 84 percent of patients can share their vitals at least 16 days a month, which is important because a lot of these patients actually don't have broadband in the home. And the fact that we can do this is because we are leveraging cell phone carriers in these local regions to transmit data. And so we have been able, with technology advances, to broaden access in very meaningful ways and in ways that are likely the highest impact we can have in the U.S., which is turning the tide on chronic disease.

Unfortunately, the way that Medicare reimbursement works for these services today is they are indexed by the geographic payments. And so, effectively, in rural communities you are paid anywhere from 20 to 30 percent less than in urban communities. And as Congress we have the opportunity to level the playing field and ensure that patients across the country have access to cutting-edge technology, which is only going to get better over the coming decade.

Chairman SMITH. So I would assume that reimbursements in rural communities that were, you said in your testimony, 25 to 30 percent less, that clearly has a huge impact on the business decision that providers would have, and whether they are focusing their efforts in a higher-reimbursed geographic region, correct?

Mr. ALTCHEK. Yes, these programs typically cost Medicare between 5 and $600 a year, on average, per patient at the national payment rates. And that is for 12 months of 24/7 monitoring, cell-connected devices that transmit data daily. In the grand scheme of the cost of these patients, which is generally 15,000 to $30,000 a year, on average, to Medicare, it is a small cost. But if that $500 goes down to 350, $400, it becomes unsustainable in rural communities. And these are already the communities that are struggling the most financially, clinically to stay afloat.

Chairman SMITH. Thank you. I now recognize the ranking member, Mr. Neal, for any questions.

Mr. NEAL. Thank you, Chairman, thanks. This was very, very helpful.

You just triggered, Mr. Altchek, in my memory, an interesting question that has been part of the challenge that we have faced on the very issue that you raised. The idea, I think, as you have accurately described it, and we have had conversations that have been really good with both sides here, is not to ask urban areas to take a smaller slice. The answer is to bake a bigger pie so that people can participate, and I am all in on that suggestion.

Dr. Mehrotra, your testimony today was really good, as the others have offered, and the research applications and the impacts of telehealth as you have described them tee up a couple of pretty good opportunities. We extended in 2022 pandemic-era flexibilities for telehealth, hospital at home, remote patient monitoring with the intention of collecting more data to inform on patient outcomes. But it struck me that in your testimony you have emphasized that it is still a lack of data that plagues us in trying to analyze quality and equity. That seems like a glaring gap in our understanding.

But what types of data do you think we need to determine success for patients and policy care in the home, which we all support?

And, what data is sufficient to ensure patient safety?

What types of things should we consider when thinking about acute care hospital-at-home programs?

Dr. MEHROTRA. Thank you for that great question. There is—one of themes I want to bring up here is that emerging evidence is there. But just as you emphasized, there is a lot to learn. And maybe I will hit upon a couple of places where I think there are really important holes.

We recognize in a lot of research that right now these amazing technologies are not being used equally across the nation, and we have a lot of interest. And how do we make sure that everybody is using these technologies? How do we do so? What are the different kinds of innovations that we can use, that we can do to try to improve that?

For example, health systems. Others are investing in digital navigators to help patients figure out this very confusing, at least at first, enterprise. Do those work or not?

People have brought up the idea that in rural communities what we can do is we can have TAPs, Telehealth Access Points, where we can set up, I don't know, at a library, a clinic where people can go there. If they can't get a video connection from their home, they can have a telehealth visit. That is a really interesting idea, but we need more research on whether that is effective or not.

So I wanted—that is one area that I think is really important is we want to make sure that these technologies that are used are available to all Americans. What actually works we don't know right now.

Mr. NEAL. And as a follow-up, you have indicated, in your testimony, that poor deployment of telehealth could instead increase longstanding disparities already exacerbated by COVID–19. How would you suggest that we might proceed with telehealth and other home-based care services that would bridge gaps and drive toward more equitable care, rather than exacerbating disparities?

And what types of data, again, do you think success might look like?

Mr. NEAL. Right. I think your question really hits upon an important, I sometimes see it as a misconception, the challenge, the idea that if we offer one of these really promising services, those in rural and underserved communities are going to be most likely to use it. I think the data is pretty clear that it is actually the opposite. And often those coming, say, from wealthier communities are more likely to use these technologies.

So, the real question that you are hitting upon is, how do we make sure that it is equitably available to everybody? And so those are how do we target those communities? What kind of investments can be made in there? What kind of programs do we need to support rural hospitals, for example, in making sure that they have that promising technology in their emergency department? Those are the kinds of investments in areas that I think we really need to do more work in.

Mr. NEAL. Thank you.

Thanks, Mr. Chairman.

Chairman SMITH. Thank you. Mr. Buchanan is recognized.

Mr. BUCHANAN. Thank you, Mr. Chairman. I want to thank all of our witnesses.

Mrs. Maddux, let me ask you. You make it sound so easy. I am in Florida, I represent part of the Tampa Bay area, the region there, and deal with a lot of seniors and the challenges they have. And they make a lot of progress, but you make it sound very manageable. You have got a beautiful family. What is your secret?

Mrs. MADDUX. It is not a secret. I would definitely say that I am incentivized by being able to take care of my family and being able to be with my family.

I agree with you. It is definitely not something that I think if somebody who had, you know, for example, a mobility issue or something that was impeding their ability to do this, there would be some complications. But I think in people in those circumstances that they are able to work with a care partner, if it is a spouse or a child or a friend for—or someone told me this morning that she is a little bit short, and so she can't lift boxes very—from high shelves, so she gets her neighbor to come and move the boxes for her.

All of the things that I do, I promise you, I do—I have not spent as much time in school as some of the people here, so all of the things that I do, it can be done by anybody. It just—you just have to be willing to do it. And I think that if you are given the opportunity for autonomy and control over your health, it is possible to do—you know, take your vitals, take your blood pressure, you know, take your temperature——

Mr. BUCHANAN. Let me tell you, you are a superwoman, I can tell you that much, to be able to manage that, because I see what our kids are managing with their grandkids, and it is a lot of work, and you don't have those challenges.

Mr. Underhill, let me ask you, how long might you have been in the hospital if you had stayed at the hospital and not went back home?

Mr. UNDERHILL. It would have been three days, and it required the administration of intravenous antibiotics over three days to resolve the situation.

Mr. BUCHANAN. You think you would have been out in three days?

Mr. UNDERHILL. I would have.

Mr. BUCHANAN. Okay. Do you have any sense of the cost if you would have stayed there? I am just curious.

Mr. UNDERHILL. I am afraid I do not know.

Mr. BUCHANAN. Okay.

Mr. UNDERHILL. No, no, I do not have the difference in the cost differential in that.

Mr. BUCHANAN. Yes. Dr. Starr, let me ask you. We talk about, you know, telehealth. I think it is clearly the future. Being in Florida, many of our seniors are an hour away, half hour away, two hours away. But when you think about, you know, the mountainous regions of the country, a state like Colorado, you know, it is five times—it is four times bigger or three times bigger than Florida. How do you manage that in terms of where people—how is that working out in terms of people—do they have to move back

and forth for a three-hour drive initially or something? Or how does that work?

Because this is clearly a road that we are going to—I think we are going to end up going down in a very aggressive way. That is just my opinion.

Dr. STARR. Yes, thanks for that question. It depends on the situation. Many of our interactions we can do fully remotely, and we can have a patient seen by a specialist and they can get the data they need remotely to take great care of the patient, I think equivalent care of that patient.

Other situations, they will come in once—our tele-oncology is a great example. They will come to the big center to get their biopsy, to get the initial diagnosis. Everything is set up, and then we will do all of their treatment in their home community.

Mr. BUCHANAN. But how far might they be away, some of your patients, in terms of accessing your facilities or the hospital?

Dr. STARR. A hundred and fifty, two hundred miles.

Mr. BUCHANAN. Yes, that is the thing I think a lot of people don't understand.

Dr. STARR. Yes.

Mr. BUCHANAN. Can you touch on home infusion, too, how you——

Dr. STARR. Yes.

Mr. BUCHANAN. How that works for you, and what makes sense and what doesn't make sense, or how we can help you with that, as well?

Dr. STARR. Yes, so I appreciate that. I think home infusion is an area of massive opportunity, and one of those that is actually kind of a no-brainer for me.

We have patients now that are Medicare patients that, under the current part B regulations, they go to a skilled nursing facility just to get IV antibiotics, or they will have to, if they are in a rural community, travel a great distances just to get an infusion. Home infusions in rural areas under Medicare don't exist, essentially. They are—it is incredibly rare. And, you know, Mr. Smith's—you know, his proposed legislation helps a lot with the Part B piece to provide more benefits to allow us to expand that.

Mr. BUCHANAN. Thank you. Let me just close.

Mr. Chairman, I would like to submit for the record the written testimony of Ms. Ashley Graves, who greatly benefitted from the promises of home infusion. And with that I yield back.

Chairman SMITH. Without objection.

[The information follows:]

March 11, 2024

Dear Members of Congress,

My name is Ashley Graves, and I'm honored to offer this statement for the record on my personal experience accessing home-based care to the House Ways & Means Subcommittee on Health hearing on March 12, 2024, titled "Enhancing Access to Care at Home in Rural and Underserved Communities."

Throughout my journey, I have encountered numerous challenges navigating my medical conditions while balancing the responsibilities of parenthood. From the diagnosis of Crohn's disease at a young age to the complexities of managing multiple health conditions, my story underscores the profound impact that access to home-based care can have on individuals and families facing similar struggles. As I share my experiences, I hope to shed light on the importance of expanding access to home infusion services for patients, ultimately advocating for policies that prioritize patient-centered care and improve health outcomes.

Balancing My Medical Conditions and Parenthood

I've been receiving intravenous (IV) infusions for over half of my life, following my diagnosis of Crohn's disease when I was 11 years old. Since then, I've had other diagnoses requiring me to add more doctors and more treatments to my routine. Growing up, I felt like I was constantly in a hospital setting whether it be seeing specialists, primary care appointments, scopes, surgery, or hospitalizations. In fact, I would often joke about having my mail forwarded to the hospital as I got older.

I received my very first infusion medication at Vanderbilt University Medical Center when I was 15 years old — a treatment called Remicade. When I graduated high school a few years later, I went to Middle Tennessee State University. That was about an hour drive to Vanderbilt each way. I would continue Remicade infusions every four weeks until I was 19 years old, until I became pregnant with my son my freshman year of college. While the doctor said Remicade was safe during pregnancy, I opted not to continue. I didn't know if one day there would be a class action lawsuit on TV asking, "Did you take Remicade when you were pregnant and does your child suffer from X"? I'm so proud to say that my son Landon was born perfectly healthy, is now 15 years old, and has the most compassionate heart I've ever known.

The Burden of Frequent Travel to a Facility

After having my son, I went through numerous medications trying to find something to help my symptoms, including participating in *four* clinical trials trying to find an appropriate treatment. Then, eleven years ago, I was started on intravenous immunoglobulins (IVIG) every four weeks. We saw some results, but it wasn't the level of improvement we wanted to see, so it became an every other week treatment. Not long after that, I was diagnosed with gastroparesis and small bowel dysmotility. Essentially, my digestive tract became partially paralyzed. I saw a doctor at Cleveland Clinic who recommended I change my IVIG treatment to a weekly basis because it would help both my Crohn's & my motility disorder.

I'm from a small town called White House just north of Nashville, TN. All of my doctors and specialists were at Vanderbilt. I was traveling about 70 miles round-trip each week. Sometimes, more than once a week, as I would also have to go in for my regular appointments. My son was little and I knew once he started school, this would no longer be a tenable situation. And I didn't have much help — I was a single mom, and both of my parents are deceased. My incredible grandmother raised me and was the only help I really had. I had been asking my doctor for a very long time if we could switch my infusion to home rather than the clinic in Nashville. Even the doctor at Cleveland Clinic tried to recommend that at-home infusions would be best for me. However, that recommendation received a resounding "no" from my specialist at Vanderbilt.

My infusion required I have a driver because of the medications I had to take before each infusion to prevent allergic reactions. This was quite the predicament. Once my son was old enough, he had to be at school everyday, but I also had to be at Vanderbilt from 8AM until 4PM every Thursday. I'd leave around 6:15AM & return home around 5:30-6PM. My only help was my 75-year-old grandmother, who honestly wasn't in good shape even back then — but was the only person I had to take Landon to and from school when I was at the doctor or in the hospital.

I was faced with a decision. Do I commit to allowing my son to miss a day of school every week indefinitely, or do I just drive myself and let my grandmother take care of Landon? Can you imagine having to make a decision like that at just 25 years old? My health versus my child's education. Ultimately, I made the decision to drive myself. Driving tired was a risk I took because without my treatment, I wouldn't be able to be the mom I desired to be anyway.

Another challenging aspect to infusions at the clinic was feeling well enough to get there. I have inflammatory bowel disease — Crohn's. The short description of this disease is "ulceration and inflammation of the digestive system effecting everything from gum to bum". I always say the hardest thing about being sick isn't being sick. It's the fact that it's unpredictable. There were many times I would have to miss my treatments because I couldn't get too far away from a bathroom. I was miserable and I was unable to get to the relief I needed to heal my gut. This resulted in worsening of the disease & more frequent hospitalizations.

Relying on Caregiver Support

So here we are again… unable to be there for my son. I would be at the hospital for weeks at a time. In fact, I missed his first two weeks of kindergarten. Those are the moments I will never have with him again. I spent several months that year unable to simply walk up & down my stairs. My 'quality time' with him was every night at 8PM.

I was on IV nutrition, known as total parenteral nutrition (TPN). My grandmother was helping with my TPN until Landon expressed that he wanted to help and do it himself. So, I let him. There's a bag for vitamins & electrolytes and another one for fats & lipids. At 6 years old, Landon knew which bag I needed each night. He would get it from my fridge, bring it up, and together we would set up a sterile field to work cleanly and reduce infection risk. He learned how to use syringes to draw up medications from the vials, how to "prime the line," check for blood return, and work the pump that

controlled the flow of the TPN. While it broke my heart that he had to do that at just six years old, it also gave me some peace because he was able to feel helpful, not scared.

This situation had another layer of frustration. I could do my TPN at home on my own, access my own port, run my IV hydration everyday, but I still had to drive to Nashville for my infusions every week. I ended up missing a few months of treatment. As a result, I now have a permanent ileostomy.

I would go on to make this 70-mile round trip to Nashville every week until 2018 when I moved with my fiancé to Alexandria, VA. I found an incredible immunologist here that has allowed me to have my infusions at my home. And after 14 years, I finally felt like I could have a more "normal" life.

Home Infusion Changed My Life

Typically, when we hear about home infusion services, we tend to think of the elderly, not young people. But health does not discriminate when it comes to age. I used to think I didn't want to live to be very old because of how hard it's been in my younger years. Home infusion services changed that for me.

Since moving to Alexandria and receiving my infusions at home, I feel substantially better simply because I don't have as much of the mental stress associated with the weekly drive. Anyone familiar with autoimmune diseases will know that stress is a number one trigger for flare ups, and I'm elated to tell you that I've had far fewer flare ups since moving here. I hated driving to Nashville every week. I hated being in traffic. I hated going into a hospital setting. Not having to go into an environment like that is a big, positive change. Walking into those places every week was like an enormous neon light reminding me that yes, I am really sick and will be doing this for the rest of my life. And yes, it's just as depressing as it sounds.

Now, my nurse comes to me. I never thought I'd be able to say this, but I no longer have to worry about missing a dose because I'm too unwell to make it to the clinic. She also serves as someone to talk to — even to vent to — as someone who understands the limits my health has on my body. It's not uncommon for families to get tired of hearing, "I don't feel well today." It's not that they don't care; they just don't understand the exhaustion chronic illness causes.

Lastly, I feel like the obvious importance of having home infusion services is to reduce exposure to potential infections. I have a chronic autoimmune disease, an immune deficiency, a heart condition, malnourishment, ileostomy bag, a feeding tube, and a port in my chest. As you can imagine, I am highly susceptible to infection. Avoiding the hospital setting dramatically reduces risk of serious and potentially life-threatening infections.

I used to tell people that I felt like I was a professional patient and a part-time mom because I spent way more time in a hospital than being home with Landon. I felt guilty when I wasn't home, but I also felt guilty when I was sick at home. Home infusions actually give me a sense of freedom that I've never had before. I feel like I have more control over every aspect of my life. I don't feel like too much time is being taken away from my family to manage my health.

Today, at 35 years old, I still have all the same health issues, but I'm happier, less stressed, and I feel more "normal." I don't dread my infusions anymore because it's in my own home. I look around and see all the things and people that make me feel whole. I am finally a full-time mom and part-time patient.

Conclusion

My goal is to help ensure people like me don't miss out on moments in life that only happen once. Moms and dads should never have to choose between taking care of themselves or showing up for their child. A grandparent should never miss out on the early days of a new grandchild. I've been able to watch my son start high school, participate in art shows, go to school dances and have his first girlfriend. There are many more milestones as he gets older and I cannot wait to experience each one with him.

In conclusion, I urge you to consider the profound impact of home infusion services on patients like me. Access to these services not only improves health outcomes but also preserves the quality of life for individuals managing chronic conditions. Let's work together to ensure that all patients have the opportunity to receive care in the comfort and safety of their own homes.

If you have any questions, please feel free to contact me at ashley.graves27@yahoo.com.

Sincerely,
Ashley Graves

Chairman SMITH. Mr. Doggett.

Mr. DOGGETT. Thank you very much, Mr. Chairman, and thanks to each of our witnesses. I will focus on telehealth.

I offered bipartisan legislation in the last Congress that was supported by 22 health-related stakeholders after chairing a Health Subcommittee meeting in which Dr. Mehrotra testified and worked with then-Ranking Member Devin Nunes to craft reasonable legislation that would extend telehealth for a couple of years, permit some data collection, and implement some modest guardrails that were recommended by the Medicare Payment Advisory Commission, or MedPAC, to prevent the looting of Medicare through telehealth fraud schemes. This legislation would have required an in-person visit within six months prior to ordering high-cost lab testing or durable medical equipment, as well as an audit of some of the outlier clinicians whose orders for these high-priced services and devices are largely made through telehealth appointments.

The Government Accountability Office, the Health and Human Services Inspector General, the Justice Department, and my own constituents have exposed a number of fraudulent schemes involving telehealth and DME and lab testing. Here is what has been happening. Information for some patients, who were only seeking COVID–19 testing, were fraudulently used to build Medicare for cancer genetic tests and allergy tests without any medical necessity or the patient's knowledge. In other words, expensive medical equipment in no way needed by the patient was ordered.

Last June, the Justice Department brought charges against 78 providers in an elaborate telefraud scheme involving 2.5 billion fraudulent orders for braces and other items. These providers were found to have used these ransacked profits to purchase yachts, luxury vehicles, and jewelry. This case built on an earlier action involving $10 billion in telefraud.

These schemes happen regularly at both large and small scales. In September another health executive pled guilty to 44 million in fraud using telehealth to order medically unnecessary DME, particularly back and knee braces, as well as genetic testing. In September, one nurse practitioner pled guilty to ransacking 7.8 million taxpayer dollars. Just last week I had an Austinite contact me because she discovered someone had fraudulently billed Medicare for $20,000 in DME for her.

So my belief is we need more telehealth. We don't need any more telefraud. And prevention is so much better than prosecution after the damage is done and the taxpayer pays the bill. Unfortunately, I have been unable to get enough interest in the Preventing Medicare Telefraud Act that I have offered this year that focuses on eliminating this kind of fraud with reasonable measures.

Dr. Mehrotra, let me just ask you, given the considerable amount of telehealth fraud which has occurred, namely this ordering of DME and unnecessary lab tests, would you agree that we need guardrails to protect taxpayer dollars at the same time as we extend telehealth?

Dr. MEHROTRA. Thank you so much for that question. I think it is a critical issue that you are raising. We will have issues of overuse and this outright fraud, which is abhorrent and using taxpayer dollars. And so we do need such guardrails.

I think the one guardrail that you propose, which is that for selective tests that are being overused such as DME or cancer screening tests, we do—requiring in-person visit requirements for that is not a substantial burden on clinicians, and I think it would at least be one check on that kind of behavior. So I think those kinds of guardrails writ large are necessary as we continue to use telehealth.

Mr. DOGGETT. Thank you so much. And though I know you are a big advocate for telehealth and the benefit it offers, particularly in rural areas, would you agree that Congress should not extend telehealth coverage under Medicare without at the same time instituting reasonable checks to prevent this kind of fraud?

Dr. MEHROTRA. Yes, I think we do need to allow for the Medicare program to continue to introduce those kinds of guardrails, because we need to make sure we do this in the most cost-effective manner.

Mr. DOGGETT. And from a clinical perspective, do you believe that targeted, modest guardrails, the kind I have outlined, would unnecessarily hamper patient access?

Dr. MEHROTRA. Yes, I don't think that that kind of in-person visit requirement is—it is very selective, and I don't think it would impact most Americans in any substantial way.

Mr. DOGGETT. Thank you. Well, I hope we can get it considered further in this committee.

Thank you very much.

Mr. ESTES [presiding]. And now I recognize the gentleman from Nebraska, Mr. Smith.

Mr. SMITH of Nebraska. Thank you, Mr. Chairman. Certainly, thank you to our witnesses, as well. It is truly amazing to hear about new technologies that have expanded the boundaries of access to health care.

Every day we see new devices which allow services that could previously only be performed in the hospital to be accessed from home. Greater access to high-speed Internet and the development of apps which can securely connect patients to providers from virtually anywhere in the world make it easier than ever before for patients to access the care that they need.

Telehealth has been a game changer for access to care in rural areas such as my district in Nebraska. I have been advocating for expanded telehealth since even long before the pandemic. While access to telehealth was pretty limited before the pandemic, during COVID many of us quickly learned to rely on our phones and computers for routine health care needs.

Unfortunately, most of the flexibilities we have come to rely on in the years since the pandemic are set to expire at the end of this year. I am pleased that this committee has already advanced legislation I introduced with Representative Steel to permanently extend first-dollar HDHP coverage for telehealth, but more action needs to be taken on critical geographic and originating site flexibilities and audio-only options for those without access to high-speed Internet.

Even though telehealth has made it easier than ever for patients to connect with their providers, it is innovation in medical devices that has most dramatically expanded the ability of patients to safe-

ly receive care in their homes, as you have pointed out. For example, innovations in home dialysis technology have made it a more accessible option than ever before as new innovations make operations easier than ever, such as the Tablo device which can operate with just normal tap water, an electrical outlet, and a drain.

But lack of adequate Medicare coverage can often create roadblocks to adoption of new technologies that expand safe home access to care. That is why I introduced the Home Dialysis Risk Prevention Act, which would reduce the risk hemodialysis patients face of serious complications from venous needle dislodgement. This legislation would ensure adequate Medicare reimbursement for the sensors and alarms that can detect when the blood return needle slips loose, putting a patient at risk of serious blood loss or even death.

In other cases we have the technology available to safely perform services like home infusion, but have to painstakingly legislate individual conditions into lists of "medical and other health services" in order to have Medicare cover them. In this case, Medicare is already explicitly allowed to cover home infusion of intravenous immunoglobulin for primary immunodeficiency diseases, but would require an act of Congress. My legislation, the Medicare IVIG Access Enhancement Act, to allow for the same technology to administer the same treatment for patients with CIDP or MMN.

Rather than having to legislate every single new indication or new device, we really need to look at broader reforms Medicare coverage for home-based care. That is why this Congress I introduced the Expanding Care in the Home Act to jumpstart the conversation on how Medicare needs to approach a whole spectrum of home-based care, including home infusion, home dialysis, and in-home primary care labs or diagnostics. I hope today's conversation leads to further legislative action on removing outdated regulatory and statutory barriers to accessing these new and revolutionary technologies for greater access to care in our homes.

Dr. Mehrotra, from your perspective I was wondering, as a physician and a professor, what areas of care in the home under discussion today do you believe are most impacted by outdated regulations?

Dr. MEHROTRA. I think the one exciting thing is there—a number of these technologies—I think home dialysis would be a great example of where we need to expand the use of home dialysis across the nation would be one where the regulations, I think, are quite problematic.

I think remote patient monitoring would be another example of where I am excited about the potential, but I think there are important changes to the regulations that can be implemented to really increase their use.

Chronic disease is one of the greatest drivers of health care spending in the United States, and morbidity, and anything we can do to improve chronic disease care is really important.

Mr. SMITH of Nebraska. Mr. Altchek, would you like to reflect on that a bit? Do you see any particular area where there is more difficulty to enter or to give patients more options?

Mr. ALTCHEK. Yes, I think, building on Dr. Mehrotra's point, in chronic disease management we just need to do a much better

job as a country. We have a, as you know, rapidly aging population, the majority of which have one or two chronic diseases. We don't have enough clinicians to take care of these patients. We need to adopt technology and more modern services as fast as possible to deal with the issues that are coming our way.

Mr. SMITH of Nebraska. Right, very well.

Thank you, I yield back.

Mr. ESTES. Thank you. I now recognize Mr. Thompson.

Mr. THOMPSON. Thank you, Mr. Chairman. And to all the witnesses, thank you very much for being here.

I have been working on telemedicine, telehealth, seemingly forever. I am a big believer, and I think that we can save money, time, and lives so long as we do it correctly.

As some of our witnesses mentioned, many of the telehealth options available to seniors on Medicare today are slated to expire at the end of 2024, and I would like to focus my questions on how this committee and how Congress should be approaching that deadline.

So Dr. Mehrotra, I thought you did an excellent job in your testimony describing the balance we need to strike on telehealth. To use your term, we need to prioritize high-value cases and protect against low-value utilization. I also share your observation that we can't really take away telehealth, that the genie is already out of the bottle and it is working, especially in the field of mental and behavioral health.

So, as we think about the upcoming December 2024 deadline, can you talk a bit more about the steps we can take to make telemedicine permanent and give patients and providers certainty while avoiding low-value utilization?

Dr. MEHROTRA. Thank you for the question, and I think that there are a number—in terms of improving the value of these kinds of technologies, it—a lot of it really focuses on ensuring that the patients who are going to benefit most from that technology are going to be the ones who receive it. I talked about how I felt, that remote patient monitoring was a great example of how we can improve chronic illness management. But a lot of the patients who are receiving remote patient monitoring today are doing just fine with their chronic illness. We need to focus our money, our resources, our time on those patients who are doing poorly. And so how do we implement regulations to encourage that kind of targeting would be one example.

You also raised the issue of mental health treatment, and I think an important regulation that we should be thinking about is the current—as of January of next year we will be implementing an in-person visit requirement before a patient can receive mental health treatment via telemedicine. And that is an example of where I think that kind of regulation may impair Americans from getting the mental health treatment that they need, and is another thing we should be considering.

Mr. THOMPSON. Thank you very much.

Dr. Starr, you mentioned that you have an emergency medicine telehealth program. I think you said over 90 percent of the patients at the clinic ultimately do not need to go to the ER, even though they think they do. And each ER visit costs over $1,400, on average. That is exactly the kind of thing I am focused on. As I said

earlier, I want to reduce unnecessary care, not expand it, and it seems that your telehealth ER program does just that.

Can you tell me a bit more about how that works when the ER doc visits a patient virtually, and the patient thinks they need to go to the hospital? Do you find that your providers are able to accurately assess whether the ER visit is needed?

And what are some of the examples of conditions or symptoms that might make a patient think they need to go to the ER?

Dr. STARR. Yes, so this program is done in conjunction with InstaCares, both our virtual InstaCare and physical InstaCares. So patients who present to be seen—and we are expanding to primary care doctors, as well—they will prevent [sic] for a complaint—for example, chest pain. And currently, a lot of those patients are immediately sent to the ER. Instead of that happening, they will have a virtual visit with an ER physician who can see them, review what information we have, and then decide, if they were going to go to the ER, what workup would we give them, and then can we do that outside of the ER.

For example, if they need a CAT scan to look for a blood clot, we would arrange for a rapid outpatient CAT scan, and they would go get it done. And we would follow up on the results.

Mr. THOMPSON. And does that fall under the category you mentioned earlier about preventive care? Is that a type of—is that an example, that——

Dr. STARR. A type of preventive care. Additionally, you know, like we have been talking about with diabetes and a lot of our chronic conditions, early identification and management of those, as well.

Mr. THOMPSON. Thank you all very much.

I yield back.

Mr. ESTES. Thank you, and I now recognize Mr. Kelly for five minutes.

Mr. KELLY. Thank you, Mr. Chairman, and it is a good hearing.

First of all, I think one of the things that we fail to—and Mr. Schweikert will be here, I am sure he is, because he has got a whole idea about disruption and what it actually means in our industry.

So whenever I was looking, trying to figure out so how much of our economy is health care, and we say somewhere between 17 and 20 percent, but then we rank eleventh worldwide in innovation, which is what Mr. Schweikert talks about all the time.

I am a type 2 diabetic. And also, in the district I represent there are great distances between hospitals and patients. And what we are doing in a lot of the veterans' places, they have a place where they can go in and sit down. It is private, and they can go online and get information.

So for all of you—now, I have got you, Mrs. Maddux, what you are able to do is incredible.

Mr. Underhill, I got to tell you, getting care on a Saturday afternoon in the fall is very much the same in South Bend, Indiana as it is in Chapel Hill, especially if there is a Notre Dame home game.

So, look, all of you are involved in this, and I really would defer to the doctors on this panel. I relate everything to the business model. I am an automobile dealer, and one of the biggest drivers

for people that are manufacturers is warranty costs. And we found a new way of doing diagnosis, where the cars can tell you what is wrong with them, as opposed to a technician trying to interpret what it is that the owner of the vehicle is telling them, as opposed to the vehicle telling them what is wrong with it.

For those of you in that business, and it is a business, and we have got to address it as a business because it is going off the charts in what it is we are able to do—and listen, I think telehealth is an incredible, incredible issue. I mean, for us to be able to sit at home and get the help we need, I think that is fantastic. For each of you that are in that business model—not so much the patients, because you rely on it for your health, right, and your health well-being. But for those of you who provide it, what role does the government play?

And I know it is—everybody always talks about the fraud, and the abuse, and everything else. I get that. That is in every single business across the country, not just in health care. What is it that you would suggest that we can do to make sure that every single dollar we invest is actually going to the care and the health of our taxpayers?

So—and you are all experts in this, because you work with it every day. Can you give us a little more of an idea? So what is it that we should be concentrating on? Spending more money is not the answer. Getting a return on the spending is the answer. So what could we do?

Dr. Starr, you can start, and Mr. Altchek, and then Dr. Mehrotra. I want to hear from you all because you do it every single day.

Dr. STARR. Yes, I—for Intermountain Health, our answer to that is to continue to move towards value-based care, where—moving away from fee-for-service, everything billed fee-for-service, towards getting paid to keep people healthy. And if we do that, then that is where everyone can benefit, you know, reducing costs and improving our margins as a health care system by reducing medical utilization that is unnecessary.

Mr. ALTCHEK. We completely agree that sensible guardrails make sense as remote monitoring and telehealth expand. In our space, there are three things that guarantee a better outcome for patients and, again, guarantee a better outcome for Medicare.

One is that on the other side of the remote monitoring there is a 24/7 care team that can actually respond to the data and make clinical decisions, whether that is ordering labs or ordering medication. So we encourage people who do deploy remote monitoring to have that 24/7 coverage.

Second is integration into the electronic health records of the local physicians. We think it is really important, if we are going to do a better job of chronic disease management, managing patients over time, we need to be sharing the data back and forth with the local physicians.

And then the third point is reporting on outcomes and metrics. You know, we believe, if we are going to be spending Medicare money, we should be responsible for reporting the outcomes to make sure the government can decide whether that is well spent.

Dr. MEHROTRA. I think the key issue that I want to emphasize is, like you, I am just so excited about these innovations, and it is exhilarating as a physician to take care of patients in a better way. But the issue that kind of is at hand here is true throughout health care, and maybe other industries also, where we introduce a new technology and we get excited about the benefits, but we also have to address overuse also.

I will give an example of cardiac catheterization, a device, a procedure that is lifesaving. I imagine many of you in this room have had that lifesaving procedure. But the data shows that we grossly overuse cardiac catheterization. So it is this balancing act: How do we make sure that the patients who will benefit most from that technology get it, but also ensuring, so that we use our tax dollars effectively, that we don't overuse it and give it to—deploy it with patients who are not going to benefit?

Mr. KELLY. Yes, so I want to thank you all for your testimony. I have got to tell you, just because I do this every day in my life. One of the things that are really important when you have a private sector business and when it comes to warranty work, the people who pay that bill are the people who are in every month looking to make sure—this is called oversight—that you are doing the right thing at the right time for the right reasons, and not just building for the sake of building to get revenue.

So thank you so much for all being here. And Mr. Underhill, Mrs. Maddux, good luck with your health as you go into the future. And thank you so much for being here today.

Mr. ESTES. Thank you. I recognize the gentleman from Oregon, Mr. Blumenauer.

Mr. BLUMENAUER. Thank you, Mr. Chairman. This has been, really, a fascinating hearing. A number of us have been working on these.

I appreciate, Mrs. Maddux, you talk about waiting to be waiting, and I also appreciate the fact that you have got your reinforcements here. We have membership in the Congressional Bike Caucus pins for them in a moment.

I do appreciate being able to focus on this. I must say I have some concerns about what happens with the application of private equity as we move forward with some of this. And it is just another area, if we are not careful, I think we can get run over. But this, I think, is really appropriate.

I am looking forward, with Dr. Wenstrup, to introducing legislation to extend the deadline, not the end of the year, but maybe even more than a year extension, a longer extension to be able to deal with the impact of the care at home. This is a very powerful model. I think it is timely, and I would like to continue working with the good doctor as we are moving out the door, concluding our legislative careers. But I think this would be a fitting area to be able to make some impact.

I do appreciate the notion about home dialysis. I think it is a very powerful tool. We are working with Mrs. Miller to be able to extend opportunities with home dialysis, to be able to, in terms of allowing Medicare reimbursement for in-home assistance, the professionals who can do the training, and we want to do this right. Not everybody is as adept as Mrs. Maddux. People need that help.

And providing additional education, being able to get ahead of the curve to promote in a very thoughtful way how we can realize this very powerful tool.

I like the notion that it gives a context for the patient that you don't get in a hospital setting. This will, I think, give a window into the conditions of the patients, their families, and their attitude. And these are areas that I am really fascinated about our potential. I look forward to both of these areas.

These are not partisan, and these are things that the committee has done some work, has built a record of interest and accomplishment, and I think we ought to be able to utilize that to be able to move simple, common-sense legislative proposals that don't have to be unduly complex, and they don't need to be expensive at all. Done right, and I appreciate your admonition, it will end up saving money and improving outcomes. I look forward to working with the committee, with Dr. Wenstrup, and with Mrs. Miller on progress yet this Congress.

Thank you, and I yield back.

Mr. ESTES. Thank you. I now recognize for five minutes Mr. Wenstrup, Dr. Wenstrup.

Mr. WENSTRUP. Thank you, Mr. Chairman, and thank you all for being here today.

I have lived the life of many of you and your experiences as patients and as providers, and it is true we have opportunities to do a lot here. Mr. Blumenauer and I have worked together on many things. Ms. Sewell and I have worked together on rural issues. There is a lot we can do.

But today has been kind of hitting home to me and bringing back a lot of memories. Mrs. Maddux, you know, I had a patient with end stage renal disease, and I treated him, you know, at least monthly. He had neuropathy, he had chronic ulcerations that we would heal. And you are always at risk, right? And one day he came in and he said, "I have to quit seeing you."

And I said, "Why is that?"

He said, "Because the bus schedule changed, and I can't get to you and to dialysis." Think if he had home dialysis, right? I changed my schedule so that he could still see me, by the way, we worked it out.

But understanding the challenges are there and the advantages of some of these things that actually allow people to get the care that they need and get it in a timely fashion, you know, and—but here is somebody I know, and I know him well. And so if he were to call today or later in my practice, even, I would say, "Well, you know, take a picture of it, take a picture of what is going on. Let me see if I need to send you to the emergency room or have you come right into the office. Or maybe we can wait another week." But I know the patient.

And so, when it comes to telehealth, one of the things that is important to me is that as often as we possibly can—and COVID was different—you know, we need to have a relationship where we really do know each other in person. At least at some point we have to have done that.

You know, I had a patient one time—and let's talk about home infusions. I had a patient that—at one time Medicaid didn't allow

home IV antibiotic therapy, so you had to treat a patient—I had a guy in for six weeks, he has no pain whatsoever, but he has got a bone infection. He has got neuropathy. So six weeks he sits in the hospital, getting IV antibiotic treatment. Well, he drove the staff nuts and they drove him nuts. You know, he felt fine. If we had been able to do that at home, which later we did, I mean, I celebrated when we started to have this type of an option.

But you have got to have the appropriate workup, you know. So we are talking about guardrails. You can't just say, "He gave me a call, it sounded like osteomyelitis, I am going to prescribe six weeks of antibiotic treatment at home." So you have to have some in-person clinical evaluation, all these types of things. I think that is important, you know, as we are talking about how we are going to proceed forward with these things that can be a great advantage.

You know, for a lot of surgeries, elective surgeries, we are doing things pre-operatively now to try and make sure we get the best outcomes so people can live the healthiest lives possible that you said, Dr. Starr. So I really appreciate all these comments.

If someone is smoking, we say, "Look, this is an elective procedure. You stop smoking, you got a better chance of healing." You know, "You lose weight, you got a better chance of healing," all these things. And then post-op, you go home with a pulse oximeter, we are getting your blood pressure, we are getting your temperature. Some people don't know they have an infection, but you can tell by what they can report back to you every day. These are great things, and you nip things in the bud.

But I do think back, you know, when we are on call, you are taking care of your patients. If they called, you weren't billing for it, we just did it. And we decide we have come on in, go to the emergency room, and then we start to be able to do photos, but these are patients that you know. So I worry about some—not tremendously, because I don't think there is that many bad actors out in there, you know, but there is always some—you know, you can't just set up a business, you know, call me, and I will start ordering tests and do all these things, and I have never seen you. So we have to have some guardrails and parameters, I think, to work, because it would be best practices, anyway.

But I think common sense comes into play on a lot of these things. You know, most doctors, they are concerned about their reputation, they are concerned about the outcomes. They really don't care—I don't care what Washington thinks. I am concerned what my patients thought, and what my community thought, and my colleagues thought about how we were taking care of people.

So I don't really have a question because you are covering down on it so well today. But where we could have help is continue to give us input on what you think for guardrails and best practices, and how we establish this.

But look, patients are less anxious and heal better when they can be at home. And the more you can get them in that environment that they are comfortable with, the better off the patient care can be, and the better results you are going to get. So hang with us, help us drive on, and let's work together through this. So no questions because you have already answered them.

Thank you, I yield back.

Mr. ESTES. Thank you. I now recognize Mr. Pascrell for five minutes.

Mr. PASCRELL. Thank you, Mr. Chairman. Mr. Chairman, it struck me that during this conversation with excellent witnesses, all of them, that health is so personal. But it is a good reflection of how we can come together in the Congress of the United States, believe it or not. I think it is so important that we learn from each other on this. We are fortunate to have some doctors on the panel, but so many health matters.

I mean, it is an example for sustenance, transportation to work. Think about these issues. You know, I am from an urban setting all my life. The first time I went to Montana, I was lost. [Laughter.]

Mr. PASCRELL. Lost. Environmental matters. We seldom listen to each other because you are in another place and you have different problems. But health is a perfect example that we can move together and accomplish a lot. This is a pretty bipartisan issue today, and witnesses kept it that way, which is great.

It is truly revealing like the pandemic was revealing. We learned a lot about ourselves. We have yet to learn everything from the pandemic, the consequences in our children. We learned America's health care system has deficiencies, yawning deficiencies that must be addressed.

But the lack of quality and compassionate care is not a problem for rural Americans alone. That problem exists right in the heart of the most congested cities in America. So, we need to pay attention to each other, and we can't ignore it. There is no reason where you live determines whether you can get health care. I think we have crossed that barrier pretty well.

And no, I have never heard any Democrat or Republican solutions that solve all the problems; I don't think you will find. When we work together on these issues we control the outcome, I think.

Americans in urban communities like my own face the same endemic challenges, facilities face staffing shortages. I mean, places are closing, equities taking them over. They can't exist. They can't afford to. Don't tell me that is just the problem in the middle of southeast Alabama. It is a problem right in the midst of where all the money is supposed to be, in New York City.

Retention struggles persist. I just went to a doctor earlier this morning. The person that that doctor hired to do his medical work in the office was just fired. The equity company took over the outfit that he works for. She was fired because she was not necessary, 66 years old, single mom. Where the hell is she going to get a job at 66 years of age? Don't tell me that is just a problem in southeast Alabama or Paterson, New Jersey.

We need more data comparing health outcomes between treatment settings and payment models for the services like we have been hearing from our guests today. Home dialysis, which has been mentioned many times, must be fair to providers while not encouraging over-utilization.

And Dr. Mehrotra and Dr. Starr, can either of you share with us some of the challenges of telemedicine visits, and how we can find solutions to those barriers?

Dr. STARR. Thank you. I think the main challenge does come down to you are not there, and you can't do a physical exam. So there are evolving technologies that allow us to listen to heart and lungs and other things that definitely will help. But that physical exam piece is what we are missing. I think everything else in terms of history and evaluating the patient you can get via tele.

Dr. MEHROTRA. I would just emphasize that point, that the American people like the value of these telehealth visits, but the concern is that the physical exam is missing, and the physicians agree. And so how do we bring the physical exam to the home is really, I think, the next frontier of where we are going to see telehealth evolve.

Mr. PASCRELL. Let me ask you just one quick question. Is this pie in the sky, what I am talking about, that health can lead the way to bringing the parties together, because nothing is more personal than our health and seeing that when we work together, we can get solutions?

I don't mean problem solvers and that stuff. I am talking about, really, down-to-earth issues day-to-day. Is that pie in the sky to you, Doc?

Dr. MEHROTRA. I think that the issues that you are describing—and I would echo what you are saying, which is that the issue of getting access to timely medical care is a problem that so many Americans face, no matter where they live. And I think it is—I am so glad that we are having this hearing on this particular topic.

Mr. PASCRELL. Mr. Chairman, thank you.

Mr. ESTES. Thank you. Now I recognize Dr. Ferguson for five minutes.

Mr. FERGUSON. Thank you, Mr. Chairman, and thanks to each of you for being here.

You know, one of the challenges and the—you know, my good friend from New Jersey and I go back and forth a lot on this dais. And, you know, clearly, private equity in health care is an issue. There are things that are happening there that I have concerns about, as well. One of the biggest challenges, though, as someone that has operated a small practice in rural America—and I think that any of the providers up here will tell you the same thing—the cost of doing business because of the regulatory burden is just absolutely through the roof.

You couple that with decreasing payments for Medicare, you know, Medicaid not keeping up, and then just the unbelievable battles that private practices face every day with third-party payers, it is a model that is not working, and it is driving people out of private practice.

So, you know, I hope that as we have a discussion about private practice, I hope that we will look not just at punitive measures that may, that my friends on the other side of the aisle may look at from a private equity standpoint, but let's figure out the things that are driving people out of private practice, and it is the regulatory burden, it is the lack of payments, it is the, you know, it is—really, you know, many times we feel like David going up against Goliath. The only problem is we don't have any rocks in our pocket to sling at them a lot of times.

Dr. Starr, first to you, can you talk about how, you know, we are having this discussion about the, you know, about the physical exam. What is the link, I mean, what is the part of this where, on remote home health, that we have got a nurse, or a nurse practitioner, LPN coming in to do a piece of that, how does all of that fit with the payment model piece?

Because we talk about telehealth, which in some cases it is—in most cases it is actually a great added benefit. But how do you weave in the payment piece of this for the actual person, not the physician, but maybe the nurse that is coming out to the rural area to check on the patient?

What is the—you see the dilemma we have got?

Dr. STARR. Yes.

Mr. FERGUSON. I think we are talking about either doing telehealth or in-office visit, but there is a very real component of someone you know, of a health care provider coming to the house. How does that fit?

Dr. STARR. Yes, and currently I think that is one of the big holes that exists. You know, there, the billed amount for telehealth, you know, has been mentioned, you know, ideally can be lower because we don't have the overhead, unless that overhead exists because we need to have someone go into the home.

And so for our Hospital at Home, you know, all of that is rolled into the payment for hospital home, and we do have providers, you know, caregivers, whether it is community paramedics or nurses, in the home to do the physical assessment. And then we can do everything else virtually. So it is a model that can be really successful, but there is not a great answer yet to how to do that.

Mr. FERGUSON. Do you think it would be—and I think at some point you are going to have to segment out the various payment pieces. In offices a certain amount, telehealth a certain amount, then you have got the expense—I mean, look, having somebody drive 50 miles or 100 miles from a central location out to do something, an injection in a rural community, I mean, that costs exponentially more than the in-office visit.

Dr. STARR. Yes.

Mr. FERGUSON. So I think there is going to have to be some sort—I don't think bundling is the way to go, because I don't think you gain the efficiencies. I think you are going to have to segment out those various costs.

Dr. STARR. Well, and that is where the regulations you mentioned really come into play. For example, currently with Medicare, to do a home infusion a nurse has to start and stop the infusion.

Mr. FERGUSON. Yes.

Dr. STARR. There are—yes.

Mr. FERGUSON. Let me get my time back here.

Dr. Mehrotra, one thing that I am going to disagree with you on is the fact that you think that telehealth in an office should be paid differently than, you know, than an in-office visit. You know, you have got an impressive resume, but you have never owned a solo practice in a rural area. I think there is a disconnect from what you see theoretically to what is in practice.

That overhead still exists, that building still exists. Those—you know, the staff still exists, the electric bill still exists. All of those

things are there. I don't think that simply replacing—saying we are just going to go to telehealth and we are going to pay it less, I don't think that that is going to work, and I think it is going to exacerbate the problem of people being willing to go into private practice and practice in rural areas or, to my friend from New Jersey's comment, even in some underserved urban areas.

So with that, I would just say I think you need to do a little bit of a reality check on what it costs to actually operate a practice in a rural area.

And with that, Mr. Chairman, I yield back.

Mr. ESTES. Thank you. And now we will go two to one with majority to minority. And with that I will recognize myself for five minutes.

Thank you to our witnesses for being here today to talk about your personal experiences and helping us talk through this issue. My colleagues have raised some really important issues and questions about how we improve and expand care at home for Americans, and especially in rural and underserved communities. And I want to focus on how telehealth fits into this effort.

All of us here likely are familiar with the importance of broad access to telehealth services, the COVID–19 pandemic, if there was any silver linings out of that, it was that it underscored how important these services were. Some of you here may have taken advantage of telehealth during the pandemic and discovered just how convenient it is, and not only in a time of crisis. In Kansas, especially, telehealth bridges the gap between those who live in rural areas and who may not have easy access to certain specialties.

Allowing for greater accessibility to telehealth gives Americans living in rural areas increased access to quality and specialty health care. While telehealth is invaluable in rural areas, it benefits all Americans. Seniors and vulnerable populations benefit from the ability to meet with their doctor from the comfort of their own home. Busy parents and professionals will be glad to conveniently meet with their provider via telehealth, recouping precious hours that would have been spent commuting or in an office waiting room. In fact, nearly one in four adults report having utilized telehealth in the past month.

Now that this technology has been available for some time, we have sufficient data to show how effective and beneficial telehealth can be: 91 percent of the patients utilizing telehealth report having a favorable experience, and 78 percent are likely to complete a medical appointment by a telehealth again in the future.

There is a long way to go to ensure Kansans and all Americans have consistent, reliable access to telehealth services. To cite just one challenge, at the end of this year the expanded Medicare telehealth flexibility waivers will expire, restricting telehealth access for large segments of the population.

Dr. Starr, I think many of us would agree that the acceptance and growth of telehealth has made a significant impact on our constituents' access to care, especially in rural areas. I have long been a supporter of telehealth and view it as a wonderful tool. However, in my district we have been experiencing significant provider shortages not just for primary care, but specialty care, as well. What suggestions do you have that maybe we can continue to expand and

see telehealth as a tool, but not necessarily as a final solution to actual providers in rural areas?

Dr. STARR. Yes, thanks for that question.

One of the issues we run into is the licensing and credentialing piece for telehealth providers, particularly across states. There are opportunities, you know, to expand your pool of options if we could more easily be credentialed and licensed across states to see patients. And currently that is a very expensive and time-consuming process that limits things greatly.

Mr. ESTES. Well, thank you. And, you know, while we have previously focused on the need for flexibility for patients, I believe that we should also focus on ensuring that providers view telehealth as a valuable tool. And as mentioned before, part of that conversation should be viewed about proper reimbursements and what they should be for telehealth services.

Dr. Mehrotra, from your experience after initial startup and for material costs for technologies, what are other factors to be considered when looking at reimbursement rates?

And I wanted to follow up a little bit on Dr. Ferguson's comments and pick your brain a little bit more.

Dr. MEHROTRA. Yes, I think Dr. Ferguson and you both raised a really important issue, which is the regulatory burden. And just to put a point on this is that, if you do a surgery, it makes a lot of sense, you submit the bill. But when you are doing an individual, I don't know, a text message on a phone, or a quick phone call, or something on a portal, it doesn't make sense to have, you know, an individual bill for each encounter.

So the real growth of telehealth and the really promising technologies we have discussed today also have brought to a head of, like, how do we pay for this in a different way?

And I think one of the things I am excited about is—and we should just continue to expand upon—is trying to pay for these kinds of services with, say, for remote patient monitoring as a monthly bundled payment so you get—here is a certain amount of money, you figure out what is the most appropriate way to care for patients. We are seeing this for opioid use disorder, where we pay a—you know, a payment per month.

And I think the reason I am excited about those is that, one, it can support the technology, decrease the regulatory burden on individual clinicians for submitting all these little bills, and also allow clinicians and patients to figure out what makes sense for them under this circumstance, as opposed to right—you know, having some payment rule for that.

So I think this telehealth growth and payment reform sort of go hand in hand.

Mr. ESTES. Yes, yes, and that is good because, I mean, we talk a lot about the fee for service and the restrictions that are on that, and paying to not be sick as opposed to paying to be healthy and staying that way.

So thank you all for your time and effort in talking through this.

So I will yield back, and now I will recognize for five minutes the gentlewoman from Alabama, Ms. Sewell.

Ms. SEWELL. Thank you. I want to thank all of our witnesses here today.

I represent Alabama's 7th congressional district. It is actually my home district. I grew up in this district, in the rural part. It includes Birmingham, historic civil rights cities like Birmingham, and Montgomery, and Tuscaloosa. Roll Tide. [Laughter.]

Ms. SEWELL. But it also includes nine counties of the rural Black Belt. So, I was really excited that we are having this hearing today. My district is both urban and rural, and I can tell you that home health and the ability and expanding services that one can receive at home really is important for a big swath of our population. It is not the sole solution.

But I can tell you that my father was a nine-time stroke survivor, and lived for a decade at home. And everything from the rehabilitation to his breathing treatments that he had to have, all of those were done at home. And I believe my dad's life expectancy was extended because we have extended services that are available at home.

So my question to you, Mrs. Maddux, is, if you had an opportunity to have the President of the United States right here in front of you, what would make your life easier? What do you want us to know that would make your life, as a home dialysis patient, better on the health care side?

And I can tell you that your lovely children, who were behind you, are proof positive that this type of treatment has worked well for you and your family.

Mrs. MADDUX. Yes, thank you for your question. I definitely agree with that. Having the home dialysis option is what allows me to be a better mom. That is full stop there.

But in terms of ways to improve it, we talked a lot about innovation several times here. And for me, I have seen a lack of innovation across home dialysis to begin with. You know, everything is being automated these days and simplified. But the process to conduct my treatments at home is——

Ms. SEWELL. Very personal.

Mrs. MADDUX. It is very personal, and it is involved. There are a lot of steps, there are a lot of things to do.

But then I have also found that the equipment and machines that I have to use, personally, my dialysis machine has been replaced probably four or five times. It is a very scary thing when you have to do your treatment and your machine doesn't work.

Ms. SEWELL. Exactly.

Mrs. MADDUX. And——

Ms. SEWELL. I know I have limited time. I wanted to just acknowledge that access is not just the medicine or therapy. Also, access is having the equipment that you need. In fact, one of my constituents in Birmingham, he owns a small home help, medical device equipment company, and their company provides home oxygen and hospital beds and other health care necessities for patients to receive treatment in the comfort of their home. And we know that at-home would be lost without having these DME providers outside of the hospital setting.

And so, I think it is important that we, as a committee, will make sure that home infusion drugs and biologics covered through the Part D Durable Medical Equipment benefit must support an

extension of the 75/25 blend rate that allows small businesses like the one that I just described in Birmingham to exist.

I think that we have to really burrow down into health equity and what that means, and it is an access issue. But in this great country of ours I believe that health care shouldn't be a luxury, but it should be a right of every American. In order to do that we have to bring costs down. It is not just the cost of the actual medicine or the doctors, it is also the equipment and being able to provide it.

On telehealth I want to just say that it is not just telehealth. Audio-only may be necessary in certain areas that don't have broadband, and I am excited to work with this Administration on the $100 million that is going to every state to deal with broadband. My plea is that we start at the places that need the first mile, not the middle mile, not the last mile, but the first mile. And until we do that, I think we have to have innovative ways of making sure that we provide health care, and that includes at home. Thank you.

Mr. ESTES. Thank you. And now I recognize Mr. Smucker for five minutes.

Mr. SMUCKER. Thank you, Mr. Chairman, for holding this hearing. I want to thank the witnesses, as well, for traveling to be with us here today.

You know, it is exciting to hear some of the things that are happening in the medical field. We are going to see, I think, big changes in the way that care is delivered. Patients will be experiencing better care over the next years and decades, and better care in rural and underserved communities, as well. So it is really exciting. You know, we are talking telehealth, remote patient monitoring, home dialysis, home infusion. These all have sort of reached in some way the mainstream. They are cost-effective ways to deliver quality care to patients right in the comfort of their home.

It reminds me. I have served in the state senate in Pennsylvania prior to serving here, and we were talking a lot at that time about changing the system to allow folks to age in their homes. And what we found was there were a lot of regulations, there were funding reimbursement methods that prevented quick movement in allowing people to age in their homes as they wanted to do. We found there were better outcomes. It is what elderly folks wanted, and actually, it turned out to be less cost, as well. So it is was like it was win-win-win, but it was very hard to move to that because of regulations that were in place and so on.

And so, Mrs. Maddux, you mentioned the lack of innovation. I don't know that I will even have a question here, but you mentioned the lack of innovation in the dialysis space. And I wonder at times whether, you know, that is—if it is a funding, if it is the regulations that are in place, and I think the answer is probably yes.

And so what we ought to be thinking about is how we can sort of unleash that innovation, and encourage and incentivize that innovation, and I think we will find we will get a lot of data. And if I do get time for a question, maybe, Dr. Starr, I will ask you. I would be interested in what data that we have available now

about the improvement in the quality of care under some of these home health care things.

But before I do that, because I may run out of time, I do—I want to talk just briefly about a bill that I have introduced with Mr. Doggett, another member of the committee, called the Medicare Home Health Accessibility Act, which is related to some of the things that we are talking about today. This bill would establish occupational therapy as a qualified Medicare home health benefit. Currently, a Medicare beneficiary can't receive OT services in their home unless there is also nursing, physical therapy, or speech services at the same time. And this bill would change that.

So again, one of these regulations that I think is preventing better care—so this would ensure that seniors with conditions like low vision, dementia, diabetes, and other conditions, instead of having to travel, would be able to receive that care that helps them safely manage activities of daily living and thrive in their homes.

And studies have indicated that OT services like this will create savings for the Medicare system by preventing falls and other accidents that too often lead to emergency room visits and maybe even hospitalizations.

So again, with this bill we want to ensure that the care that patients experience in an acute care setting is also available to them right at home, which is what many of you are doing, as well.

And so, I appreciate the work of Mr. Doggett. We have cosponsored this bill together, and hope that we can see that passed.

But so, Dr. Starr, I don't have a lot of time left, but I do—can you build a little bit on what I mentioned, and describe what we are seeing in terms of patient outcomes across the board?

Are they equivalent at this point?

And I know we are early on in some of these things, but are they better? Are the outcomes better when patients receive services like hospital at home or other treatments in their own homes, rather than in a facility?

Dr. STARR. Yes, thanks for that question.

So the data is still young, but what is emerging is that it is at least as good, leaning towards better in many of the outcomes. I think many programs have shown a decrease in readmission, 30-day readmission to being treated at home. There is definitely, you know, a reduction in infections like nosocomial infections, because you are not around those dangerous bacteria.

I think one of the really encouraging things is we also have seen it is not dangerous to be treated with hospital at home.

Mr. SMUCKER. Right.

Dr. STARR. We are not seeing bad outcomes for patients being treated, and it is a safe model in that sense.

Mr. SMUCKER. Sure. And I think, as we go along on this, we will get more and more studies. So that would be good to hear.

We certainly know—I think, Mr. Underhill, you talked about it, Mrs. Maddux—the difference that has made in your lives to be able to receive care in the home. So I appreciate both of you, all of you for sharing your stories and being here with us today. Thank you.

Mr. ESTES. Thank you, and now I recognize Mr. Fitzpatrick for five minutes.

Mr. FITZPATRICK. Thank you, Mr. Chairman, for holding this timely hearing on enhancing access to care at home. I would like to use my five minutes, Mr. Chairman, to share a story about one of my constituents, Joe Fiandra. Joe is a Warrington, Pennsylvania resident and a proud Army veteran. Joe was diagnosed with a debilitating disease called amyloidosis. He unfortunately passed away in June of 2022.

And Mr. Chairman, I would like to enter into the record the testimony of Joe's wife, Helen, which explains Joe's situation and the importance of expanding access to those receiving home infusions.

Mr. ESTES. Without objection, so ordered.

[The information follows:]

After two years of visiting specialists, my husband, Joe Fiandra, was diagnosed with a debilitating and at that time fatal disease called Amyloidosis. Research had produced a medicine that the doctors believed could prolong Joe's life and so he began the necessary infusions every three weeks.

We lived in the northwest suburbs of philadelphia and had to travel well past center city to reach the infusion center. It took about two hours, since Joe could not drive and I didn't drive on highways. Because we had to be at the hospital by 8:00 a.m. we were up at 4:00 a.m. so we could get him ready, have breakfast and get him into the car by 6:00 a.m. The total infusion process took approximately six hours because he had to have IV's of premeds one hour prior to the infusion and then wait one hour before and after for any possible reactions. This meant that we were out of the house from 6:00 a.m. to about 5:00 p.m. (with travel time) and I had to make arrangements to have someone tend to our pet.

We did this for sometime and then we were able to come in at II:00 a.m., which helped in the morning but added an extra hour to our rush-hour return. We made it work because Joe was using a walker at that time.

When the pandemic hit, Joe was advised that he could have his infusions at home with a visiting nurse and that was wonderful. By then the premeds could be given orally and I was able to give him the 10 pills in his morning oatmeal one hour prior to the nurse's scheduled visit and, since Joe also suffered with Crohn's Disease, he could use our bathroom which had been renovated to accommodate his condition.

Unfortunately, Joe was only permitted to have three home infusions before the funding was cut off. Because it was so much easier, Joe inquired of Medicare, our insurance company and the manufacturer if we could provide some sort of co-pay to allow him to continue. After much communication, it was determined that the cost would be about $9,000 every three weeks. Obviously, we could not afford that.

We were permitted to go to a new infusion center in New Jersey and, even though it was in a different state, it cut our travel time by a half-hour each way. However, now when we were one hour away from the center, I had to pull off the road and spoon feed the ten premeds to Joe with apple sauce because he couldn't swallow them with water in the car.

Because of the pandemic I was not permitted to enter the center and so I dropped Joe off and had to drive all the way home, wait a few hours and then drive back, pick him up and drive home again. I did this because there were no stores or restaurants allowed to be open where I could wait for him. My daughter lived in New Jersey but I was afraid of infecting her family with Covid because I had some limited contact with others who were dropping off their loved ones. Later I was permitted to go inside the center but had to wait in line with Joe in a wheelchair because I had to be issued a pass to accompany him. The infusion time was a little shorter but weather was always a concern. We had to postpone visits when it snowed or there were icy

conditions. Sometimes we were caught in really bad summer rain storms or delayed because of bridge openings.

As the months went by, Joe lost more of his hand and leg strength and I had to ask a security guard to help me get Joe out of the car and into a wheelchair. It was awkward and sometimes Joe would lose his balance and flop onto the chair, causing some bruising to his hip and upper part of his legs. The guard also had to help me get him back into the car.

When he needed to use the bathroom facilities, I was able to push his wheelchair and then help him into the bathroom. But, after a while, Joe could no longer grasp the bars to help me lower him and we had to ask the nurses to aid him. It took two nurses because he was heavy and he couldn't help them. Joe told me that even though the nurses were very kind and caring, he was humiliated at having strangers lower his clothing, lower him and then pull up his clothing. He had always been an independent person and sometimes when he returned to his infusion chair he had tears in his eyes and I knew what he was feeling.

This went on for about two and a half years but then Joe's body was really failing and it was much more difficult to get him back and forth for his infusions. Our son would come over in the morning before work to help me get Joe into the car and return at night to lift him onto his chair and push him up the ramp into our home.

His last infusion was the worst. Everything had gone smoothly until the security guard and I were trying to get Joe into the car. His legs gave out and he began to fall. Fortunately, the guard was able to grab Joe and push him against the side of the front seat and hold him about ten inches from the ground while I ran for help. Three nurses rushed over and it took all of them to lift Joe onto the seat and get his legs in the car. It was so very scary and really embarrassing for Joe. He told me on the way home that he wanted to stop the infusions because he didn't want that to happen again.

As it turned out, Joe's condition took a turn for the worse and he spent his last weeks in and out of ER's, hospital stays and rehab until he passed away in June 2022.

As his wife and a witness to all that he went through, I am not saying that if Joe had been permitted to have home infusions he would have been cured, nor am I saying that home infusions would have prolonged his life. I am saying what I believe to be absolutely true - that home infusions would have provided Joe with a better quality of life, a life definitely less stressed, much safer, and much more private and that would have meant a lot to both of us.

Thank you for listening to our story. I am sure that other people are experiencing similar problems and I sincerely hope that you will do something to alleviate their trials.

Helen Fiandra

Mr. FITZPATRICK. Thank you, Mr. Chairman.

After his diagnosis, Joe began the necessary infusions every three weeks. To get to the infusion center, Joe and his wife drove 2 hours in order to get to their appointment by 8:00 in the morning. His infusion process took a total of about six hours. The pandemic allowed Joe to get his infusions done at home with a visiting nurse. However, once this funding was cut off, Joe was informed that he would have to pay about $9,000 every 3 weeks if he wanted to continue to receive his infusions at home. This was not feasible for their family, and they ended up having to drive to a different state to get infusions.

Unfortunately, Joe's situation is being lived out by many Americans, which is why I introduced the Joe Fiandra Access to Home Infusions Act of 2023, in honor of Joe, to codify a proposed rule that would expand access to home infusion treatments to ensure that these lifesaving treatments are covered under Medicare benefits.

Dr. Starr, can you speak to your expansive home infusion program, and explain the critical importance of home infusion therapy for individuals like my constituent, Joe?

Dr. STARR. Yes, thank you. It is a vital program that provides care on an average of 1,500 patients per day in the State of Utah that are managed by our home infusion, receiving everything from IV antibiotics to IV fluids, immunologics, biologics, chemotherapy, electrolyte replacement, and nutrition, and we have massive opportunity to expand that if we can remove some of the limitations that you mentioned in your bill.

Additionally, just taking advantage of the existing technologies, where many of our current home infusion patients we actually teach to manage their own infusions, and we provide them with the medications and the equipment to do so safely, with backup from nursing if needed.

Mr. FITZPATRICK. Thank you, sir.

And Mr. Chairman, this bill is bipartisan. It is open for cosponsors. I hope that both my Republican and Democrat colleagues on this committee will join me in helping millions of Americans get access to the home care they need.

I yield back.

Chairman SMITH. Thank you. Now I recognize Ms. Chu for five minutes.

Ms. CHU. Dr. Mehrotra, thank you for your testimony as both a professor of health care policy and as a physician.

I am the only psychologist in Congress, and I am especially interested in the impact that telehealth can have on expanding access to mental health services.

I am also concerned that, if deployed poorly, greater use of telehealth may increase health disparities.

So, Dr. Mehrotra, in your written testimony, you noted that 13 percent of mental health specialists have closed their in-person clinics and now only see patients via telemedicine. You also mentioned that many of the new direct-to-consumer telehealth companies are growing rapidly using venture capital funding.

While telehealth-only providers may improve access through innovative models, does this trend have the potential to limit access to mental health care for underserved populations?

And, what are the guardrails you think are necessary for direct-to-consumer telehealth services when it comes to delivering mental and behavioral health care?

Dr. MEHROTRA. Yes, I think I really appreciate you bringing up this issue of the rapid growth of these virtual-only companies for, you know, maybe—the biggest presence is in mental health treatment, but across the health care spectrum we are seeing these companies.

And I think that they both have both real positives, potentially increasing access to care and getting into rural and underserved communities, but I also share your concerns that we could have issues where we could exacerbate disparities.

And also, you didn't say it, but I think it is also we all know that there are concerns about the quality of care that some of these companies could provide, as well as prescribing behavior that we think is inappropriate.

I think there is—a key issue here is that right now we have very little data. This is a real data gap in terms of understanding what the impact of these companies are. And I think we need to, as they are starting very quickly to enter the Medicare program, ensure that we are actually monitoring these companies effectively so that they are not leading to these negative consequences that you raise.

So I really appreciate the question. We need more research on these companies.

Ms. CHU. Thank you for that. Dr. Mehrotra, I wanted to talk about other issues for underserved populations. For instance, limited English proficiency. Right now, that, of course, remains a significant barrier for access to health care for more than 25 million limited-English-proficient Americans.

As we discuss the need for expanded telehealth, I need to make sure that those who are limited English proficient are not left behind. So, can you discuss the ways that telehealth can help expand access to care for those who face language barriers in the health care system?

Have we seen examples of telehealth successfully serving these communities in recent years?

And conversely, can you discuss any risks or challenges that expanding telehealth services could pose to this population?

Dr. MEHROTRA. Yes, I think that—I appreciate you raising this issue of limited proficiency because, for many patients, going—one of the real advantages of—potential advantages of telehealth is to facilitate interpreter services. If you speak a specific dialect, you may go to the clinic and not have someone who actually speaks that dialect and allow—telehealth can facilitate that, because you can have a interpreter who is very far away who could join a three-way call. So I think that is one of the real positives that we could see.

But I also do have concerns that in the—what we find in the data is that we—sometimes clinicians make assumptions, and I am probably guilty of that also, where I assume that a patient can't do a video call and I have to do it via a phone call and so forth,

or—and so I think we also need to be focused on the provider community to ensure that all patients, including those with limited English proficiency, are offered the video visits, and we don't make assumptions that they can't do it.

Ms. CHU. Dr. Mehrotra, you also discussed the digital divide in many low-income communities of color. How about the disparities in telehealth utilization and the issue of Internet access and insurance coverage?

What guardrails would you suggest Congress look at to help ensure that vulnerable communities are not left behind in the expansion of telehealth?

Dr. MEHROTRA. Yes, I think that this is a really important point that, as I said before, we cannot make the assumption that if we offer this to everybody, those underserved communities are going to use it more. If anything, we are going to see it less. So what are we—what investments do we make among—and I think it goes two ways. One is obviously focused on the clinicians themselves, ensuring they are offering those visits, and they have the resources and the ability to invest in telehealth.

But I also recognize that this is not just health care. There is a little aspect of the digital divide is not limited there, and is—I often wonder a lot about which is the lane of health care providers. Should they be addressing these issues, or do we need more community resources to allow for, say, digital navigators that can both help with health care, but also education, work? There is—you know, the digital divide goes across all of our lives, not just health care.

Ms. CHU. Thank you, I yield back.

Mr. ESTES. Thank you. Now I recognize Mr. Schweikert for five minutes.

Mr. SCHWEIKERT. Thank you, Mr. Chairman. You look good in the seat.

Mr. ESTES. Thank you.

Mr. SCHWEIKERT. And I apologize for the crying that was back there. That is my 20-month-old—and yes, I have a 20-month-old.

Mr. Altchek, can you and I actually—will you work with me conceptually for a moment? I want you to say—think about the platform you offer today. If you actually had a supportive Federal Government, or one that just got the hell out of the way, what are you capable of?

And part of this is I am a bit of a believer that the solution—and I know this is mostly about rural access, but we have seen data that makes it very clear for certain urban populations, for my tribal populations in Arizona southwest that using technology is capable of being a credible disruptor, and that we—often our rules, our inability to allow an algorithm to write a script, all these other things that go on, we have the barriers that actually keep the miracle from happening.

I mean, you just had a language question. Well, the fact of the matter—you and I know that the adoption of certain of the chats—I mean, the IRS is doing it this tax cycle—can pick up dialects and different languages, and it is remarkably accurate.

We need to move faster. So I come to you and say, all right, you have this platform. What does it look like five years from now if

you could run amok and adopt technology? How much more—how much healthier and wealthier would our society be?

Mr. ALTCHEK. Thank you, Congressman.

And I think the important policy consideration is where Medicare goes, so goes the country. And so the decisions you make here are incredibly important.

Mr. SCHWEIKERT. So your argument—so your first comment is on reimbursement.

Mr. ALTCHEK. Yes, well, reimbursement and, I would say, what is possible here. There is easily 30 million Medicare patients who struggle from hypertension, out-of-control diabetes, and heart failure. And we—the data shows consistently that we can get patients' blood pressure under control in very meaningful ways, we can double the percentage of patients who get to that magic 130 over 80 blood pressure number, and we can do it for 10 million patients, likely, in the U.S.

In heart failure—there are seven million patients with heart failure in the U.S. Number-one cause of hospitalizations for Medicare patients, we could likely reduce those hospitalizations by upwards of 20 to 30 percent, which is tens of billions of dollars.

Mr. SCHWEIKERT. Thank you. Can I give you a quirky one that we have worked on for years, but we get ignored? Sixteen percent of all health care spend is those not taking their meds. You know, their calcium inhibitor, their statin, whatever it may be. You work with the prescribers. And for $0.99 there is a pill bottle cap that beeps at you in the morning if you haven't taken your calcium inhibitor, your hypertension medicine.

Mr. ALTCHEK. I mean, exactly——

Mr. SCHWEIKERT. And let's see, 16 percent of U.S. health care would be $600 billion a year?

Mr. ALTCHEK. American technology has a great track record of making things better, cheaper, and faster. And I think we can accomplish a lot together.

Mr. SCHWEIKERT. You could even do it with an app that just pings you in the morning.

Mr. ALTCHEK. Text message, phone calls. There is a lot of opportunity.

Mr. SCHWEIKERT. So what do we do to get platforms like yours to actually start to move that sort of techno magic, and make people—and help people be healthier?

And at the same time, you know, you have a country that is collapsing financially with the growth of debt. We are borrowing, what, $95,000 a second, and almost every dime of the growth of that spending is interest and health care costs.

Mr. ALTCHEK. Yes.

Mr. SCHWEIKERT. What do we do to change—instead of taxing more, you know, we can keep taxing people and spending more money, but that is the financing side. We are doing almost nothing to change the cost of health care.

So we have had a running discussion with many of my rural colleagues—I represent an urban-suburban district, saying, okay, so you want to spend this much money to run a piece of wire out to the middle of my Navajo Nation chapter house for a fraction of a fraction of a fraction, and tomorrow I can give them a satellite

dish. I can set up Starlink or something of that nature, and instantly they have telehealth. Except they are not the ones who are here lobbying to run the wire, which we have been doing for 25 years and never seems to get there. Tell me how I am wrong.

Mr. ALTCHEK. I don't think you are wrong. And I think hearings like the one today are important because providers need to know and clinicians need to know which investments they need to make for the long term. And if reimbursement changes can be made permanent, then providers will do the right thing and build out these technologies and deploy them at scale.

Mr. SCHWEIKERT. Okay. Thank you.

Mr. Chairman, with your permission, I have a number of articles we would like to submit for the record in the adoption of technology, improving access, particularly in my tribal communities, and crashing the price of health care, and that it is our own policies that are the barrier to the adoption of these technologies.

And with that, I yield back.

Mr. ESTES. Without exception, so ordered.

[The information follows:]

New AI Smartphone Tool Accurately Diagnoses Ear Infections

PITTSBURGH — A new smartphone app developed by physician-scientists at UPMC and the University of Pittsburgh, which uses artificial intelligence (AI) to accurately diagnose ear infections, or acute otitis media (AOM), could help decrease unnecessary antibiotic use in young children, according to new research published today in *JAMA Pediatrics*.

AOM is one of the most common childhood infections for which antibiotics are prescribed but can be difficult to discern from other ear conditions without intensive training. The new AI tool, which makes a diagnosis by assessing a short video of the eardrum captured by an otoscope connected to a smartphone camera, offers a simple and effective solution that could be more accurate than trained clinicians.

"Acute otitis media is often incorrectly diagnosed," said senior author Alejandro Hoberman, M.D., professor of pediatrics and director of the Division of General Academic Pediatrics at Pitt's School of Medicine and president of UPMC Children's Community Pediatrics. "Underdiagnosis results in inadequate care and overdiagnosis results in unnecessary antibiotic treatment, which can compromise the effectiveness of currently available antibiotics. Our tool helps get the correct diagnosis and guide the right treatment."

According to Hoberman, about 70% of children have an ear infection before their first birthday. Although this condition is common, accurate diagnosis of AOM requires a trained eye to detect subtle visual findings gained from a brief view of the eardrum on a wriggly baby. AOM is often confused with otitis media with effusion, or fluid behind the ear, a condition that generally does not involve bacteria and does not benefit from antimicrobial treatment.

To develop a practical tool to improve accuracy in the diagnosis of AOM, Hoberman and his team started by building and annotating a training library of 1,151 videos of the tympanic membrane from 635 children who visited outpatient UPMC pediatric offices between 2018 and 2023. Two trained experts with extensive experience in AOM research reviewed the videos and made a diagnosis of AOM or not AOM.

"The eardrum, or tympanic membrane, is a thin, flat piece of tissue that stretches across the ear canal," said Hoberman. "In AOM, the eardrum bulges like a bagel, leaving a central area of depression that resembles a bagel hole. In contrast, in children with otitis media with effusion, no bulging of the tympanic membrane is present."

The researchers used 921 videos from the training library to teach two different AI models to detect AOM by looking at features of the tympanic membrane, including shape, position, color and translucency. Then they used the remaining 230 videos to test how the models performed.

Both models were highly accurate, producing sensitivity and specificity values of greater than 93%, meaning that they had low rates of false negatives and false positives. According to Hoberman, previous studies of clinicians have reported diagnostic accuracy of AOM ranging from 30% to 84%, depending on type of health care provider, level of training and age of the children being examined.

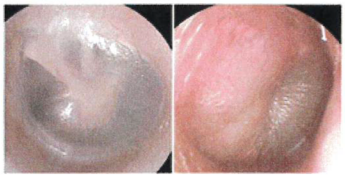
“These findings suggest that our tool is more accurate than many clinicians,” said Hoberman. “It could be a gamechanger in primary health care settings to support clinicians in stringently diagnosing AOM and guiding treatment decisions.”

“Another benefit of our tool is that the videos we capture can be stored in a patient’s medical record and shared with other providers,” said Hoberman. “We can also show parents and trainees — medical students and residents — what we see and explain why we are or are not making a diagnosis of ear infection. It is important as a teaching tool and for reassuring parents that their child is receiving appropriate treatment.”

Hoberman hopes that their technology could soon be implemented widely across health care provider offices to enhance accurate diagnosis of AOM and support treatment decisions.

Other authors on the study were Nader Shaikh, M.D., Shannon Conway, Timothy Shope, M.D., Mary Ann Haralam, C.R.N.P., Catherine Campese, C.R.N.P., and Matthew Lee, all of UPMC and the University of Pittsburgh; Jelena Kovačević, Ph.D., of New York University; Filipe Condessa, Ph.D., of Bosch Center for Artificial Intelligence; and Tomas Larsson, M.Sc, and Zafer Cavdar, both of Dcipher Analytics.

This research was supported by the Department of Pediatrics at the University of Pittsburgh School of Medicine.



Telehealth Utilization Higher Than Pre-Pandemic Levels, but Down from Pandemic Highs

Team A: Kersten Bartelt, RN; Alex Piff
Team B: Steve Allen, MD; Eric Barkley
Last updated 21 November 2023 • Check for updates at EpicResearch.org

Key Findings:

- While telehealth usage has declined since the initial peak early in the pandemic, it is still used much more broadly than before the pandemic.
- In mental health, infectious disease, OB, and transplant departments, the proportion of encounters that used telehealth in the third quarter of 2023 is higher than other specialties.

Telehealth is used for a wide range of acute and chronic medical conditions in both specialties and primary care. It allows healthcare providers to reach underserved populations, such as those in rural areas.[1] Telehealth became a necessary means of healthcare delivery during the peak of the COVID-19 pandemic. We previously reported increased rates of telehealth early in the pandemic.[2] In this study, we are seeking to understand how telehealth use now compares to telehealth use before the pandemic.

We evaluated 475,229,277 telehealth and in person encounters between Q2 2019 and Q3 2023. Pre-pandemic, across all specialties, telehealth was a low proportion of visits, averaging less than 1% of visits in the last three quarters of 2019. In Q2 2020, the proportion of telehealth visits peaked across all specialties, with the highest rates in mental health (65.5%), endocrinology (55.5%), geriatrics (55.2%), transplant (52.2%), and GI (51.5%). Across all specialties, we saw another, smaller spike in telehealth in Q1 2022 when the omicron variant contributed to another spike in COVID cases. As of Q3 2023, the specialties with the highest rates of telehealth utilization were mental health (37%), infectious disease (11%), OB (10%), and transplant (10%). The specialties with less than 1% of visits occurring through telehealth in Q3 2023 include ophthalmology, podiatry, and wound care. This likely reflects the hands-on nature of the care provided by these specialties.

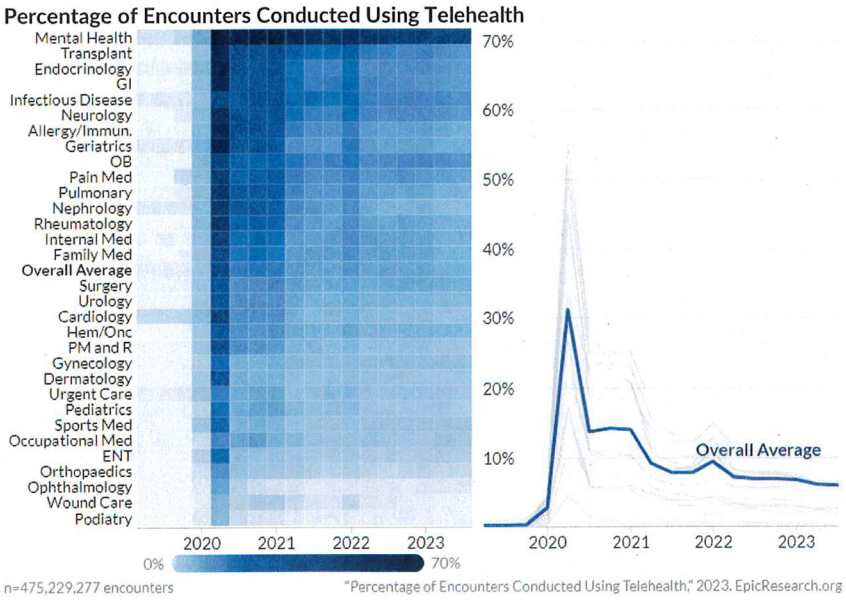


Figure 1. The proportion of visits in each specialty that are completed using telehealth sorted by average proportion of telehealth encounters over the study period.

These data come from Cosmos, a collaboration of 222 Epic health systems representing over 220 million patient records from 1,272 hospitals and more than 27,200 clinics from all 50 states and Lebanon. This study was completed by two teams that worked independently, each composed of a clinician and research scientists. The two teams came to similar conclusions. Graphics by Brian Olson.

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2. *Expansion of Telehealth During COVID-19 Pandemic*. (2020, May 5). Epicresearch.org. https://epicresearch.org/articles/expansion-of-telehealth-during-covid-19-pandemic/

Data Definitions

Term	Definition
Study period	Q2 2019 – Q3 2023
Study population	Patients who had a **virtual visit** or **in person visit** during the study period.
Virtual visit	Any encounters of types: • "Telemedicine" • "Telephone" or "Telephone Visit" with a billing code

	• "Office Visit" with a CPT billing code of 99441-99443 These encounters are categorized by the **department specialty** in which they occurred.
In person visit	Any encounters of type "Office Visit," except those with a CPT billing code of 99441-99443. These encounters are categorized by the **department specialty** in which they occurred.
Department specialty	Group categories of department specialties were: Allergy/Immunology: Allergy, Allergy and Immunology, Immunology, Pediatric Allergy, Pediatric Allergy/Immunology, Pediatric Immunology Cardiology: Adult Congenital Heart Disease, Advanced Heart Failure and Transplant Cardiology, Cardiac Electrophysiology, Cardiac Rehabilitation, Cardiology, Cardiovascular Disease, Clinical Cardiac Electrophysiology, Electrophysiology, Interventional Cardiology, Pediatric Cardiology, Pediatric Cardiology Center Dermatology: Dermatology, Dermatopathology, Pediatric Dermatology Endocrinology: Endocrinology, Endocrinology, Diabetes & Metabolism, Pediatric Endocrinology ENT: Otolaryngology, Otolaryngology/Facial Plastic Surgery, Pediatric Otolaryngology Geriatrics: Elder Care Services, Geriatric Medicine, Gerontology GI: Gastroenterology, Hepatology, Pediatric Gastroenterology Gynecology: Gynecology, Maternal & Fetal Medicine, Maternal and Fetal Medicine, Midwifery, Obstetrics, Obstetrics & Gynecology, Obstetrics and Gynecology, Urogynecology, Women's Health, Women's Health Care, Ambulatory Hem/Onc: Hematology, Hematology and Oncology, Hematology-Oncology Clinic, Hematology-Oncology Specialty Care Area, Medical Oncology, Oncology, Pediatric Hematology, Pediatric Hematology and Oncology, Pediatric Hematology-Oncology, Pediatric Oncology Infectious Disease: Infection Control, Infectious Disease, Infectious Diseases, Pediatric Infectious Disease Mental Health: Behavioral Health, Behavioral Health Clinic, Counseling, Developmental – Behavioral Pediatrics, Domestic Abuse Support Services, Marriage and Family Therapy, Mental Health, Neuropsychology, Pediatric Psychology, Post Trauma Therapy and Support, Psychology, Psychotherapy, Social and Spiritual Support, Child and Adolescent Psychiatry, Geriatric Psychiatry, Neuropsychiatry, Pediatric Psychiatry, Psychiatric/Mental Health, Psychiatry Nephrology: Dialysis Clinic, Nephrology, Outpatient Hemodialysis Clinic, Pediatric Nephrology Neurology: Clinical Neurophysiology, Neurology, Neurology Clinic, Neurophysiology, Pediatric Neurology, Spinal Cord Injury Medicine Obstetrics: Same categories as Gynecology if the woman is pregnant Occupational Medicine: Occupational Medicine, Preventative Medicine/ Occupational Environmental Medicine

	Ophthalmology: Cornea Ophthalmology, Glaucoma Ophthalmology, Glaucoma Specialist, Neuro- Ophthalmology, Ophthalmology, Ophthalmology Clinic, Pediatric Ophthalmology, Pediatric Ophthalmology and Strabismus Specialist, Retina Ophthalmology, Retina Specialist Orthopaedics: Adult Reconstructive Orthopaedic Surgery, Foot & Ankle Surgery, Foot and Ankle Surgery, Hand Surgery, Joint Surgery, Orthopaedic Surgery of the Spine, Orthopaedic Trauma, Orthopedic, Orthopedic Surgery, Pediatric Orthopaedic Surgery, Pediatric Orthopedic Surgery Pain Medicine: Interventional Pain Medicine, Pain, Pain Clinic, Pain Management, Pain Medicine PM and R: Outpatient Rehabilitation Clinic, Physical Medicine and Rehabilitation, Rehabilitation Podiatry: Orthotics, Pediatric Podiatry, Podiatric, Podiatry Primary Care: Adolescent Medicine, Adult Health, Adult Medicine, Ambulatory Care, Chronic Care, Clinical Child & Adolescent, Developmental, Developmental and Behavioral Pediatrics, Family Medicine, Federally Qualified Health Center (FQHC), General Care, General Internal Medicine, General Practice, Internal Medicine, Internist, Medical, Medical Clinic, Pediatric Internal Medicine, Pediatrics, Physician's Office, Preventative Medicine, Primary Care Pulmonary: Pediatric Pulmonology, Pulmonary Clinic, Pulmonary Disease, Pulmonology, Thoracic Diseases Rheumatology: Pediatric Rheumatology, Rheumatology Sports Medicine: Exercise & Sports, Pediatric Sports Medicine, Sports Medicine Surgery: Ambulatory Surgery Center, Bariatrics, Breast Surgery, Burn Surgery, Cardiothoracic Surgery, Colon and Rectal Surgery, Female Pelvic Medicine and Reconstructive Surgery, General Surgery, Maxillofacial Surgery, Oral Surgery, Orthopaedic Surgery, Pediatric Cardiothoracic Surgery, Pediatric Neurosurgery, Pediatric Plastic Surgery, Pediatric Surgery, Pediatric Trauma Surgery, Plastic and Reconstructive Surgery, Plastic Surgery, Plastic Surgery within the Head & Neck, Spine Surgery, Surgical, Surgical Oncology, Surgical Services Clinic, Thoracic Surgery, Transplant Surgery, Trauma Surgery, Vascular Surgery Transplant: Abdominal Transplant, Blood and Marrow Transplant, Pediatric Transplant Hepatology, Transplant, Transplant Hepatology, Transplantation Urgent Care: Urgent Care, Urgent Care Center Urology: Pediatric Urology, Proctology, Urology Wound Care: Wound Care

Table 1: Percentage of Encounters Conducted Using Telehealth

Specialty	N	2019 Q2	2019 Q3	2019 Q4	2020 Q1	2020 Q2	2020 Q3	2020 Q4	2021 Q1
Mental Health	14,432,456	0.8%	0.9%	1.1%	7.2%	65.5%	59.4%	61.1%	60.6%
Transplant	1,026,709	0.1%	0.1%	0.1%	3.3%	52.2%	29.0%	29.5%	29.5%
Endocrinology	9,119,971	0.2%	0.3%	0.2%	4.7%	55.5%	26.8%	25.4%	24.1%
GI	8,882,531	0.2%	0.2%	0.2%	4.2%	51.5%	25.1%	25.2%	25.4%
Infectious Disease	1,442,047	0.3%	0.4%	0.4%	3.5%	33.0%	22.6%	24.8%	25.3%
Neurology	9,985,565	0.2%	0.2%	0.2%	4.1%	49.6%	23.5%	23.5%	22.9%
Allergy / Immunology	1,671,539	0.1%	0.1%	0.1%	4.6%	50.3%	25.1%	24.6%	23.0%
Geriatrics	1,285,449	0.4%	0.5%	0.4%	5.5%	55.2%	27.7%	23.8%	20.6%
OB	2,374,726	0.1%	0.2%	0.1%	4.3%	31.6%	18.8%	17.8%	18.8%
Pain Medicine	3,294,936	0.0%	0.0%	0.9%	4.3%	42.0%	17.6%	19.5%	20.9%
Pulmonary	7,878,320	0.2%	0.2%	0.2%	3.7%	45.4%	20.9%	21.2%	21.1%
Nephrology	2,267,008	0.3%	0.4%	0.5%	4.1%	44.1%	21.7%	22.7%	20.6%
Rheumatology	4,534,875	0.0%	0.0%	0.0%	4.1%	46.2%	18.8%	18.6%	18.1%
Internal Medicine	70,196,560	0.2%	0.2%	0.2%	3.5%	39.3%	15.3%	16.5%	15.9%
Family Medicine	114,814,283	0.1%	0.1%	0.1%	2.7%	31.1%	14.4%	15.7%	14.7%
Overall	475,229,277	0.2%	0.2%	0.2%	2.7%	31.2%	13.6%	14.1%	13.9%
Surgery	23,927,410	0.1%	0.1%	0.1%	2.0%	23.9%	11.1%	11.0%	11.3%
Urology	9,610,862	0.1%	0.1%	0.1%	2.3%	27.1%	10.4%	10.3%	10.4%
Cardiology	31,017,969	0.9%	1.1%	1.2%	4.1%	34.6%	10.9%	10.8%	10.2%
Hem/Onc	16,047,537	0.0%	0.1%	0.1%	1.9%	22.0%	11.1%	9.9%	10.3%
PM and R	6,095,921	0.0%	0.0%	0.0%	1.9%	29.4%	10.7%	9.1%	8.8%
Gynecology	16,895,648	0.1%	0.1%	0.1%	1.4%	17.4%	5.8%	5.5%	5.9%
Dermatology	7,589,795	0.1%	0.0%	0.0%	1.7%	26.7%	5.8%	5.3%	5.3%
Urgent Care	27,742,070	0.3%	0.3%	0.3%	2.3%	13.7%	6.2%	7.1%	7.0%
Pediatrics	28,366,793	0.1%	0.1%	0.1%	1.2%	15.8%	6.6%	7.5%	7.7%
Sports Medicine	3,315,012	0.0%	0.0%	0.0%	1.9%	19.6%	5.6%	6.0%	5.2%
Occupational Medicine	1,258,745	0.1%	0.1%	0.1%	0.8%	11.4%	7.1%	8.2%	5.8%
ENT	8,656,578	0.1%	0.1%	0.1%	1.3%	17.2%	3.7%	3.4%	3.0%
Orthopaedics	25,690,539	0.0%	0.0%	0.0%	0.9%	10.4%	3.0%	2.7%	2.7%
Ophthalmology	8,937,955	0.0%	0.0%	0.0%	0.5%	7.7%	1.4%	0.9%	0.7%
Wound Care	2,227,026	0.0%	0.0%	0.0%	0.3%	4.6%	1.4%	1.8%	1.8%
Podiatry	4,642,442	0.0%	0.0%	0.0%	0.4%	4.7%	1.0%	0.9%	0.8%

Table 1 (Continued)

Specialty	2021 Q2	2021 Q3	2021 Q4	2022 Q1	2022 Q2	2022 Q3	2022 Q4	2023 Q1	2023 Q2	2023 Q3
Mental Health	54.8%	48.4%	46.2%	48.6%	43.9%	41.9%	42.2%	41.3%	36.9%	36.8%
Transplant	19.3%	16.7%	15.5%	19.5%	13.7%	12.7%	11.8%	11.8%	10.3%	9.9%
Endocrinology	15.5%	12.4%	11.8%	14.9%	10.5%	10.2%	10.5%	10.3%	9.1%	8.9%
GI	16.7%	13.4%	12.9%	15.6%	11.4%	10.7%	10.3%	10.0%	9.4%	9.0%
Infectious Disease	17.7%	16.0%	14.6%	16.8%	12.6%	11.7%	11.5%	11.6%	11.3%	10.6%
Neurology	15.6%	13.4%	12.3%	14.9%	11.5%	10.7%	11.0%	10.8%	10.0%	9.5%
Allergy / Immunology	13.6%	10.7%	10.0%	12.8%	8.6%	8.1%	8.1%	7.5%	6.7%	6.4%
Geriatrics	10.5%	9.4%	8.9%	13.0%	8.1%	7.8%	7.7%	7.8%	5.9%	6.3%
OB	14.1%	12.2%	12.3%	13.8%	10.9%	10.9%	11.3%	11.2%	10.2%	10.0%
Pain Medicine	12.9%	10.3%	10.1%	12.1%	9.5%	9.2%	9.8%	9.0%	8.3%	7.6%
Pulmonary	12.2%	9.9%	9.2%	11.6%	8.1%	7.5%	7.5%	6.9%	6.0%	5.8%
Nephrology	11.3%	9.2%	8.3%	11.0%	6.4%	5.5%	5.7%	5.5%	4.4%	4.2%
Rheumatology	10.9%	8.6%	8.0%	10.3%	7.3%	7.2%	7.5%	7.2%	6.1%	6.0%
Internal Medicine	9.4%	8.2%	8.6%	10.8%	8.2%	7.8%	7.8%	7.3%	6.2%	6.0%
Family Medicine	8.8%	8.3%	8.6%	10.8%	7.5%	7.6%	7.6%	7.1%	6.0%	6.0%
Overall	9.1%	7.7%	7.7%	9.3%	7.1%	6.8%	6.9%	6.7%	6.0%	5.8%
Surgery	8.1%	7.1%	6.9%	8.0%	6.6%	6.5%	6.8%	6.8%	6.5%	6.4%
Urology	7.0%	6.0%	5.9%	6.7%	5.8%	5.6%	5.5%	5.3%	4.8%	4.8%
Cardiology	5.8%	4.8%	4.6%	5.5%	4.1%	4.0%	3.9%	3.7%	3.4%	3.3%
Hem/Onc	7.0%	6.1%	5.9%	7.0%	5.7%	5.6%	5.7%	5.8%	5.4%	5.3%
PM and R	5.6%	4.6%	4.4%	4.9%	3.3%	3.2%	3.2%	3.4%	2.8%	2.7%
Gynecology	4.7%	3.9%	3.7%	4.3%	3.9%	3.7%	3.8%	3.9%	3.8%	3.8%
Dermatology	3.6%	3.1%	3.1%	3.7%	3.0%	2.8%	2.8%	2.7%	2.5%	2.6%
Urgent Care	3.9%	3.7%	4.2%	4.0%	3.3%	3.1%	3.2%	3.0%	2.4%	2.5%
Pediatrics	4.9%	3.8%	3.7%	4.3%	2.7%	2.3%	2.2%	2.3%	1.9%	1.8%
Sports Medicine	3.3%	2.9%	2.9%	3.2%	2.7%	2.6%	2.9%	2.9%	2.6%	2.6%
Occupational Medicine	4.8%	3.5%	2.6%	2.8%	3.3%	2.6%	2.0%	1.8%	2.4%	2.0%
ENT	2.2%	1.9%	1.8%	1.9%	1.6%	1.6%	1.7%	1.7%	1.7%	1.7%
Orthopaedics	1.9%	1.5%	1.4%	1.6%	1.3%	1.2%	1.3%	1.3%	1.2%	1.1%
Ophthalmology	0.6%	0.5%	0.6%	0.6%	0.6%	0.5%	0.5%	0.6%	0.6%	0.6%
Wound Care	1.0%	0.8%	0.7%	1.2%	0.8%	0.6%	0.5%	0.5%	0.3%	0.2%
Podiatry	0.4%	0.3%	0.4%	0.4%	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%

Mr. ESTES. Thank you. I now recognize for five minutes Mr. Hern.

Mr. HERN. Thank you, Mr. Chairman, and thanks for having this hearing. It is good to see everyone. Thank you for the witnesses for your long time sitting in the chair. But I know you are talking about things you love to talk about, so that is awesome, as well. And are those your children back there?

I am glad they are warm now, because it does get cold in here. They look great, and I am sure they are happy that their mom is healthy with the home dialysis that you are able to do. And so thanks for having them here.

You know, it is great to hear about technologies. Being an engineer, it is exciting always to see how we can use technology as technology advances. And as my colleague, Mr. Schweikert, said, you know, we could do a lot if given the opportunity. So we have to figure out how to remove these impediments to really moving health care forward in the 21st century.

And you know, as we do that and we take away the travel time—I live in a very rural state, in Oklahoma. There is a lot of work goes on to figure out how to make that happen. In many cases, first-time prescriptions that work, as opposed to trials that we—you know, you don't have to run down the block, but you don't get off the tractor to come to the doctor and you just say I am just going to live with the statins, you know, heart medicine and others.

I have worked on many pieces of legislation to support this, from telehealth services, one of the first bills that came out during COVID. I have often said that COVID took 10 years of future technology and utilization of technology and compressed it into about 18 months. And so we have to hurry up and catch up with our policies to make—you know, to catch up with technology. And so we are a little out of whack now.

I am sure that everybody in this room, not just the witnesses or the people up here, everybody in this room has had less-than-ideal experiences in a hospital or doctor's office, sometimes waiting for what seems like just a rudimentary test, a blood pressure test, you know, a blood sugar test and saying, why am I waiting? And, you know, taking a half a day to make that happen.

The stress of that and the bad experiences, and then when we hear your testimony, it really makes it plausible that we try to figure it out, all of us working together. And we have heard our colleagues on both sides of the aisle here today talk about how we need to work together. It is not a political thing, but how do we make this work so that we do protect some—you know, there is always bad actors in every industry. We want to make sure, and I know you all do, as well.

Within my lifetime it has been amazing to see how new technologies have improved the way patients can get treatment. Last year I introduced H.R. 1458, the Access to Prescription Digital Therapeutics Act, to continue my commitment to supporting innovation in health care and to make these technology advancements more accessible.

The DPTs can, you know, be used at home to treat a variety of issues. As with veterans and PTSD, we have seen many showcases here of the different technologies. I hope we can have—this com-

mittee can continue to support and expand new technologies that make patients' lives better.

Just last week I heard from a constituent who provides care at the Utica Park Clinic in Tulsa who started offering remote patient monitoring services last year. Currently, they monitor over 14,000 patients from their homes from all over the State of Oklahoma. And I have heard firsthand how beneficial remote patient monitoring is from clinicians providing these services. This in-kind—or this kind of in-home care allows for better communication between patient and provider, and improves adherence to regular testing for things like blood pressure and other vitals.

Mr. Altchek, can you tell us the vision you see for the future of remote patient monitoring, and how scalable you think these types of treatments can be?

Mr. ALTCHEK. Thank you, Representative, and we are proud to work with many constituents in your district.

I think the most exciting opportunity for remote monitoring in the chronic disease space is to truly be proactive about health care. We are incredibly reactive today, we wait until patients show up in the ED to treat their high blood pressure. And at that point it is too late.

In your district and with your patients we have seen incredible outcomes. We have seen 43 percent of patients with type 2 diabetes getting their A1Cs to goal. And the long-term implications for that in the community are massive.

And it allows patients to get care in the comfort of their own home. That is super convenient, and skips long trips to the physicians' offices.

So thank you for the question.

Mr. HERN. Well, I was able to stop by your demo booth. And if you could, just share with us what kind of savings we could see with these services. You shared earlier some of the things that—some of the successes you have had in ambulatory care and things of that nature. If you could share that for the record, that would be awesome.

Mr. ALTCHEK. Yes, our data shows that we are able to reduce the total cost of care, inclusive of the additional costs for remote monitoring, by 23 percent, primarily driven by lower ED utilization, lower in-patient admissions, lower skilled nursing facility, and lower home health.

So effectively, we are keeping patients independent and healthier at home for longer, which is ultimately our goal.

Mr. HERN. Again, thank you.

Again, I want to thank all of you for being here today and sitting and giving your testimony. But I know it is something that you really are sincere about seeing change, and we are here to work with you to make that happen. So thank you all.

Mr. ESTES. Thank you——

Mr. HERN. Mr. Chairman, I yield back.

Mr. ESTES. Now I recognize Ms. DelBene for five minutes.

Ms. DELBENE. Thank you, Mr. Chairman, and I want to thank all of our witnesses for being here.

And Mrs. Maddux, thank you for sharing your story and your time with us today. As you noted in your testimony, hundreds of

thousands of patients across the country are spending three to five hours per day, three days at an in-center dialysis clinic, often for years on end. And that does not include time getting to and from the clinic, getting your kids to school or to childcare, trying to keep a job and earn a paycheck, and trying—and juggling all the other responsibilities of being a parent.

But if more patients were able to do their dialysis treatments at home, like you, some of these stresses could be relieved. Countless studies show that the quality of life for patients dramatically improves when given the option to receive treatments at home. And, home dialysis rates in the U.S. have increased roughly 7 to 15 percent since 2011. But, we are still far behind other developed countries that have achieved much higher rates.

And so, Mrs. Maddux, I want to start off, how did you learn that home dialysis was even an option?

Mrs. MADDUX. Thank you for your question. It was something that was mentioned to me in passing when I was in clinic. You know, a nurse or a doctor would just come by and say, "Why aren't you doing this at home?" But they weren't giving me much information about what was necessary for that, or what it entailed, and I didn't know much about it.

My husband was also in dialysis for a short time, and he did dialysis at home through peritoneal dialysis. So I knew what that entailed. But it wasn't until the doctor that I have currently explained to me the benefits of doing the more frequent, shorter dialysis sessions, and then after a series of bad experiences that I had at my clinic, at that point I thought I needed to look into it a little bit more.

Ms. DELBENE. What was the process like shifting from in-clinic to at-home dialysis?

Mrs. MADDUX. Sure. So the first clinic that I was at, trying to get an appointment with my dialysis—with the home training nurse was very difficult. They were unresponsive, and they gave me some papers and pamphlets, but they didn't really help me with that process.

My doctor eventually directed me to a different nurse at a different clinic. And from there, he took care of everything. He helped with the training, he even came to my house and set up my equipment and, you know, got me going.

So with the person that I had it became much easier. But also recognizing he is the only person that works at the home training facility that he is at, and so I know that that—with the logistics, administrative work, and with the health care part of it, it can be a lot for one person.

Ms. DELBENE. And how long did it take, then, do you think, from when you first decided you were going to do it to when you finally were set up in home?

Mrs. MADDUX. Once I connected with the training nurse that did actually train me and that I work with now, it was a couple of days. He arranged for me to come into the office and to his clinic not the next day, but the day after, and I was able to start my training immediately.

Ms. DELBENE. And you feel comfortable now doing it at home?

Mrs. MADDUX. Absolutely.

Ms. DELBENE. That is great. We need to make sure that people have the resources and the information they need, and so that they can do that quickly, too. Thank you.

This is a slightly different question, Dr. Mehrotra. In your testimony you argue that policymakers should focus on expanding telehealth when it would most significantly improve health outcomes or barriers to access. And providers that participate in alternative payment models, or APMs, have the financial incentive to target telehealth use to when it is the most impactful, which seems to align well with your proposed approach. And so, I wondered, how can telehealth policy support CMS's goal of having 100 percent of traditional Medicare beneficiaries in accountable care relationships by 2030?

Dr. MEHROTRA. Yes, I think that is a—you raise an important issue, which is that if we want in a—in such an arrangement, the clinician has the responsibility both for the quality and spending of the patients. And I think that providing clinicians in those such arrangements as much flexibility as they want in terms of how to deploy—so removing any regulatory barriers, payment barriers for those specific clinicians—could be—both give them the flexibility to provide care as they see fit for their patients, but also potentially create an incentive for those clinicians to join such alternative contracts, because that could be another way of reaching CMS's goal.

Ms. DELBENE. Thank you. I am out of time.

I yield back, Mr. Chairman.

Chairman SMITH [presiding]. Mr. Kustoff.

Mr. KUSTOFF. Thank you, Mr. Chairman, for calling today's hearing. And thank you to the witnesses for appearing.

If I could, to Mrs. Maddux and Mr. Underhill, I appreciate your testimony. First of all, your testimony about how at-home care has benefitted you. Mrs. Maddux, your story was really touching and very moving, and everything that you have related during the questioning that you have had. So I appreciate both of you very much.

Dr. Starr, if I could with you, maybe a little bit different question. Can you talk about how you treat the at-home patients now? And maybe from a diagnostic or treatment standpoint—but diagnostic—what you think will be improved on two years, three years, five years out, maybe that would be better in the future, or more capable, or things that you are looking forward to, if that makes any sense?

Dr. STARR. Yes, for sure. A really fun question, actually, for me.

So number one would be improved ability to—monitoring in the home, including continuous telemetry monitoring. We could monitor heart rate and rhythm in a much improved way.

Second would be, you know, point-of-care laboratory testing in the home that could immediately give results of many more lab tests.

Third, we are seeing pocket ultrasounds coming, where even nurses can be trained and technicians can be trained just how to put an ultrasound on different parts of the patient's body, and then those images can be read either by artificial intelligence, or a radiologist, and then get almost instantaneous, you know, results that in many ways could replace chest X-rays and other imaging where

you could have a patient with a status change or new symptoms that you could immediately diagnose.

And those are a couple of the ones that just immediately come to mind.

Mr. KUSTOFF. In terms of the at-home lab testing, can you give an illustration of how you think that might work, and what you specifically test for?

Dr. STARR. Yes. So—and some of this technology exists and is being used, but there are certain lab tests that basically you need a drop of blood, and it will give you results. So, you know, metabolic panels, electrolytes, kidney function, blood counts, those sort of things. And there is a lot of work to expand what we can do with that sort of testing.

Mr. KUSTOFF. Okay, thank you.

Mr. Altchek, if I could with you, maybe the same question.

First of all, I appreciate the technology that the patients don't have to have broadband, they—you can do it based on cellular service. What are some of the things that you look for, from a technological standpoint, maybe 24 to 36 months out that aren't available today?

Mr. ALTCHEK. Thank you for the question.

We are getting the ability to monitor more vitals more frequently, which gives us better data on how to manage patients.

And then the second big piece is we are able to do it in a way that is more passive for patients. And so I think over the next few years you are going to get the opportunity to hopefully get blood pressure from potentially a simple device as a watch, or blood glucose from a watch, and not have to prick yourself. So I think there is a lot of opportunities maybe not in the next 24 months, but definitely in the next 5 years.

And the question is, you know, how are we going to use those to deliver better care?

Mr. KUSTOFF. In terms of—Dr. Starr, in terms of the monitoring from a physician standpoint, do you see—of course, we are now four years into the pandemic, four years yesterday. Do you see pushback from any physicians as it relates to care at home or telehealth?

Dr. STARR. Not pushback. I think it is a new way of doing things, and that makes it challenging. Like, it feels weird to people to do some of this care in such a different location. And normalizing it is still part of the process we are undergoing. And it is one reason volumes still aren't as high as they will be.

Mr. KUSTOFF. Mrs. Maddux, if I can with you, and I think you have said this, but I will just ask you in a different way. So you talked about having to go originally to the dialysis clinic three days a week, what you would miss in terms of your children. Now that you are able to do dialysis at home, the manner that you have done it, do you see any difference in the—pardon me for saying this—the level of care or treatment that you receive at home versus what you would see in the clinic?

Mrs. MADDUX. I would have to say yes. At the clinic that I was at before, immediately before I started home dialysis, I was finding that there was a tremendous amount of non-patient-care-related pressure that the staff was under there. For example, they were re-

quired to get the patients connected in a certain timeframe because they were required to have a certain number of patients dialyzed in a specific period of time. So when they would come over, they would have to rush through, you know, putting the needles in and taking everything. And, you know, I would try to make small talk, and they couldn't do that because they were trying to just get through their required timeframe that they had to finish by.

My doctor and my dialysis nurse, I would say we are almost like friends at this point. And I—we touched on it earlier, but the holistic care that is required for knowing the entire patient, and not just knowing, you know, the immediate care needs, but knowing everything about their life that feeds into their care, I think it is something that is valuable and has been part of my experience in home hemodialysis.

Mr. KUSTOFF. Thank you to the witnesses.

Thank you, Mr. Chairman, I yield back.

Chairman SMITH. Ms. Tenney.

Ms. TENNEY. Thank you, Mr. Chairman, and thank you, Ranking Member, for holding this meeting. And thank you to our distinguished panel here.

This is something that I think has been so necessary in my district in upstate New York, which spans hundreds of miles and across all kinds of rural communities, and it will be even larger next year. And I have seen so many people in my community who do not have adequate access to care. It is a huge problem. We had this issue where we finally got telehealth, at least, or telemedicine to the Veterans Administration through our VA clinics to get them some, especially because of the pandemic, but it was really great to have that.

Many of these people, as I know some of my colleagues have cited, have a hard time getting to these facilities. It could be a many-hour drive. In my area we have lake effect snow. Almost the entire district is in the lake effect stripe of New York State. And, you know, it has just been a tremendous burden on them.

And one of the interesting things that stumbled upon me the other day, and we have been pushing telehealth, and obviously, it was very interesting that, Dr. Altchek, you said that, you know, where Medicare goes, so goes the telehealth, I think, was what you said. Well, last year I happened to be stumbling upon a 200th bicentennial of the Town of Macedon in Wayne County, New York, a very rural area. And I walked into the library just to get set for the big bicentennial celebration, and they had in there a digital privacy booth, where patients could go and call up their doctor in a secured setting and look at their doctors, and I thought this was pretty incredible.

So I wasn't sure exactly what it was, but it was actually a test put out by the University of Rochester, Wilmot Cancer Institute and the Community Cancer Action Council, and a group of about 29 stakeholders in upstate New York to try to see if this is something we could do to bring telemedicine to rural communities. And it was interesting. This was the test site, so I was fascinated by it. And I think they are getting great results.

And again, the big question is, how do we get Medicare to get us there so we can get health care to so many people struggling

in rural communities? And that is why I wanted to ask you, Mr. Altchek, about how do we—and I know that telehealth, telemedicine is the step before we get to where you are. How do we make that—can telehealth, telemedicine be valuable in pre-determining in some ways what happens when you get to the stage where your vision is with Cadence to get people to full health care? And how do we get there?

Obviously, Medicare is going to be a big part of it, but I would just be curious about where your vision is, since you are obviously a visionary leader here.

Mr. ALTCHEK. No, thank you for the question, Representative. And my wife, who is a physician, will be upset if I don't say I am not a doctor.

Ms. TENNEY. Yes.

Mr. ALTCHEK. She reminds me of that every day.

Ms. TENNEY. No, I see doctor up there, I figured I just—

Mr. ALTCHEK. Yes. No, no, no.

Ms. TENNEY. I am a doctor of laws, right?

Mr. ALTCHEK. She would be—my wife would be very upset if I didn't say that.

But, you know, to answer your question, telehealth is a very valuable tool here. And when we think about chronic disease management, I think one of the things that is most exciting is the ability to give patients access 24/7.

And so you talked about the lake effect in your district right now. On President's Day—I guess that was three weeks ago now, Monday—we had 300 patient red alerts, which are those blood pressures above 180, as I was talking about, and 300 patients called in proactively. And the fact that now they have access to care 24/7 has a massive impact. A lot of those patients would have ended up in the emergency department if they could have gotten there.

And so the opportunity here to create a better experience for patients is very meaningful.

Ms. TENNEY. Well, thank you. And I want to just jump on one thing that just came to mind while listening to you with these lake effect problems.

One really urgent problem we have is the closure of a lot of hospitals, and most of our rural hospitals are operating in the red. One of the issues that has come up is this safe patient staffing rule that we have in New York State, and also a requirement that an RN be visible. We have had numerous people come in and constituents say that we can't even find an RN for an entire county. So how is your model at Cadence helping us?

Because, obviously, you are monitoring people at home. How do we comply with something like the safe staffing rule that is in New York and has also been proposed here on the Federal side?

Mr. ALTCHEK. I think one of the interesting opportunities with this type of chronic disease management is you can help clinicians treat more—manage more patients safely and effectively. We have such a large provider shortage in the U.S. that we need to use technology to help providers be more effective, managing more patients safely, and there is a very large opportunity to do that.

Ms. TENNEY. Great. Well, thank you so much. I appreciate the witnesses. Wonderful. I am sorry I didn't get to everybody, but tremendous to hear you all. Thank you.

I yield back.

Chairman SMITH. Mr. Kildee.

Mr. KILDEE. Thank you, Mr. Chairman, for holding this really important hearing. I want to thank the witnesses, all of you, but in particular Mrs. Maddox and Mr. Underhill, for giving us the human side of this story. I really do appreciate it. I once worked in Newburgh, and I am a PBS fan, so Mr. Underhill, I don't know if it has been raised because I have been coming and going, but I am a fan of your work on television. So thank you for that.

Last Congress, and you will hear this theme, there has been a lot of bipartisan work in this space, last Congress I joined Dr. Wenstrup, introducing the Rural Behavioral Health Access Act, which would have extended the pandemic-era policies that allowed Medicare to pay critical access hospitals for mental health services delivered via telehealth, even when the patient they are caring for is not located at the hospital.

By giving critical access hospitals, which operate in rural areas with often very limited capacity, but giving them the flexibility for how they are paid for these services, our intention was to expand access to mental health services—obviously a critical need, but particularly critical in underserved communities.

Given the demonstrated need for mental health services across my home state of Michigan, I was really happy to see this notion, this bill, in a sense, advance not through Congress, but instead through the rulemaking process at the Centers for Medicaid—Medicare and Medicaid Services. Under their calendar year 2023, Hospital Outpatient Prospective Payment System Final Rule, CMS acknowledged that allowing this policy to expire would have created harm for patients in underserved communities, and chose to extend it beyond the pandemic.

So Dr. Mehrotra, I wonder if you might just speak to the importance of this particular aspect, this particular policy toward increasing access to mental health services in our communities that have great need. Obviously, mental health is often overlooked as a part of the overall health picture.

We try to make some progress in this space, and we think that the idea that we promoted is having some value. I would like to make it permanent, but I wonder if you might just comment on how this impacts overall health.

Dr. MEHROTRA. No, I think that, obviously, the mental health needs in the communities, in particular in rural communities, is really an enormous problem.

And often what we find is—one of the things I think is really important to emphasize is that these kinds of technologies bring up a new model in the sense there is often a lot of upfront investment that you need to—fixed costs to set up that technology. And sometimes the economics don't work as well in rural communities because you just have fewer patients.

And I might give, not related to mental health, but another example which came up earlier, which is stroke care. We find that acute tele-stroke in rural hospitals is—that is where it is most ef-

fective. But we see it is the least likely to be used. And what we hear from chief financial officers in rural communities is that the economics aren't working because of this issue of fixed costs being so substantial.

So we need to think a little bit about how we make those investments in rural communities, because we might need to pay more or give them that—resources to be able to implement these really necessary technologies.

Mr. KILDEE. Well, I am glad you raised that, because my other question really has to do with what we have learned during the pandemic, the flexibilities that we provided, how that impacted underserved communities, and what other—I mean, obviously, the telehealth access to mental health care was one, but are there other sort of innovations that occurred. And I would offer this to any of the panelists. During the pandemic that we learned enough about that we ought to make sure we extend them, and absent some action we may not be able to do so? Any thoughts on that subject?

Dr. STARR. So, you know, thinking about hospital at home, I think, is a really big one.

And kind of the question was brought up a minute ago about nursing and nursing shortages. And one of the great things about hospital at home is we do a ton of virtual nursing care, and can utilize, you know, community paramedics in the home, you know, so a trained EMT who can be the nurse's hands and feet to take care of the patient while the nurse does their work remotely. And so, you know, that would be a big one that, again, could have a lot of broader impact.

Mr. KILDEE. Well, thank you. I really appreciate this panel. Thanks for your input. This has been a very good hearing. I want to thank all the witnesses.

And I forgot to mention, Mr. Underhill, you are from Saxapahaw. If you ever go to the Saxapahaw general store, make sure to say hi to my cousin Jeff, who owns and runs it. [Laughter.]

Chairman SMITH. Mrs. Fischbach.

Mrs. FISCHBACH. Thank you, Mr. Chair, and thank you all for being here, sincerely. And I appreciate all of the information.

And I will just say I represent a very rural district. Biggest town, 50,000. My folks drive hours for medical care. And so I really, really appreciate the at-home and the telehealth. And I am just wondering—and as we talk a little bit about, you know, Mr. Kildee was asking a little bit about—you mentioned community paramedics, and the—and Ms. Tenney was talking about the staffing shortages.

And Mr. Underhill, you talked about that they are coming to visit, and I believe, Mrs. Maddux, you mentioned that they are coming to visit also. So I am just kind of wondering, practically, how is that—are you able to reach those very remote areas?

And it is not like Alaska. My district isn't like, you know, you have to fly to get somewhere. But I am just concerned that when we are talking about, you know, several hours' worth of drives and things like that, if we can utilize it as well as we should be able to.

Dr. Starr, if you want to start, any of the——

Dr. STARR. Yes, that is a huge challenge. And what we are looking at doing is, again, utilizing every resource we can find. So if there are EMTs that are available, we will look at that. We partner closely with home health, and we will utilize home health nursing, you know, who are in that geography. And we even have had discussions with some of our rural hospitals as they have waxing and waning patient volumes, using some of the inpatient nurses as a way to keep them busier and not call them off, but have them possibly go do some of that work, as well.

So it is really identifying every resource we can, and utilizing it as best as possible.

Mrs. FISCHBACH. Okay. And practically, I mean, are you able to go in and set up—you know, Mr. Underhill talked about how they came in—when he was getting out of the hospital they came in, set up the Internet, the whole bit, and so they——

Dr. STARR. Yes. So we actually send patients home with a lot of that, and then walk them through the set-up at home in that situation. So we give them—we test all the equipment, we make sure everything is working correctly, and then they will leave and take that home, and we will help them set it up at home.

Mrs. FISCHBACH. Okay. Has—and maybe somewhere along the line it was mentioned, but is the issue of solid broadband—have you run into that, I mean, where we are having issues with that?

Dr. STARR. Yes, yes, for sure. And we can always—you know, for hospital at home, for example, we can take care of the patient in the hospital. We have a safe place. So we make sure, before we send them home, that we have the right connectivity, whether that is really stable WiFi or cellular coverage. Typically, cellular coverage for most of our areas.

Mrs. FISCHBACH. And then to any of the members of the panel, what are kind of the parameters for determining if someone qualifies for in-home care or at-home, or how, whatever the hospital at home, whatever the term is?

I mean, does it vary with every single diagnosis? Or how do you determine if they are able to use this?

Dr. STARR. Yes, it really comes down to we look at the care the patient needs to get better, what they would get in the hospital, can we provide that in the home. So we have gone through all our diagnoses and what it takes to take care of those, and make sure that we can actually provide an equivalent level of care.

Mrs. FISCHBACH. So you have maybe a chart that you are saying——

Dr. STARR. Yes.

Mrs. FISCHBACH. Okay.

Dr. STARR. Really extensive.

Mrs. FISCHBACH. And age and ability?

Dr. STARR. And then some patients fall outside that, and then we will huddle as a team and decide. Can we actually take care of them safely? And if the answer is no, they stay in the hospital. If yes, we will take them home.

Mrs. FISCHBACH. Okay. And Mrs. Maddux and Mr. Underhill, I know that you talked a little bit about your experience, you know, during your opening statements. And I am just curious. And I got the impression that it was positive, that both of you had positive

experiences. Was there anything that either could be improved, and I guess I only have 46—I have so many questions, but could be improved, or that was helpful?

I guess maybe just commenting on that. I am just kind of curious if you felt it was, like, something——

Mr. UNDERHILL. I was so enthusiastic, I really didn't have anything to improve it. I cannot think of a thing.

Mrs. FISCHBACH. Okay.

Mr. UNDERHILL. It has just worked flawlessly for me.

Mrs. FISCHBACH. Well, I appreciate that, okay.

Mr. UNDERHILL. Yes.

Mrs. FISCHBACH. That is very——

Mrs. MADDUX. I mean, I would say that a potential barrier for some other patients or—including myself—there is a heavy utilization on your electric bill and water bill. Garbage pickup is a big thing. And I think that, for a lot of people, that might be a barrier because they wouldn't want to see those increase in costs weigh on their family. And so that would definitely be something that could be improved.

Mrs. FISCHBACH. Yes, and I know I only have a couple—I am over time. But I suppose, when you mention that, I hadn't even thought of that, that that is not covered. That is something that is not covered. You bear those costs yourself.

Well, thank you very much, and I really appreciate all of you being here. And I am looking forward to really expanding what we have, because it is so important to folks, like, in my district. But not only that, I think the health of people—I think Mr. Underhill said it and, Mrs. Maddux, you said it, too, that it is so much better to be at home. And so I appreciate it. So thank you all very much.

Chairman SMITH. Thank you.

Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman.

Dr.—I hope I get your name right. Name, Doctor?

Dr. MEHROTRA. Mehrotra, yes.

Mr. EVANS. Mehrotra. Can you describe how the impact of hospital closures in communities will affect the demand for telehealth services?

And how can the decrease in medical workforce caused by hospital closures impact their ability to provide telehealth program options?

Dr. MEHROTRA. Well thank you, Representative. I think you—I wanted to emphasize, like, two sides of that coin.

The first is, obviously, when a hospital closes in a community, patients are going to have to, when they get care, go much farther to the nearest hospital. And I think it really—some of the technologies we have described today can really facilitate those patients from getting that care that they need.

The other side that I wanted to emphasize that your question raises, which is that—can telehealth keep rural hospitals from closing? Because there is the possibility that we bring a lot of that technology for stroke care, for mental health care, sepsis care, et cetera, to rural hospitals, and allow them to care for a broader range of patients and conditions, and allow them the finances and

so forth to stay open. So I also do want to emphasize that aspect, where telehealth can keep rural hospitals from closing.

Mr. EVANS. Studies have shown that increased access to telehealth services increased accessibility for communities of color. Can you please elaborate for communities explicitly why disparities in health equity are reduced when telehealth services are made available?

Dr. MEHROTRA. Yes, I think the—what we are finding in some of our data and we—obviously, this has been a theme of the work that we have done—is that we have the concern that, when we introduce these new technologies, we often see that, if we just offer it to everybody, it can increase disparities of care. And that is one of the greatest concerns I have and I think many of the other folks, the witnesses, share.

And so the real question is how do we target our investments, resources, reimbursement to those communities so that we don't widen disparities, but rather reduce them, which is what we all want?

Mr. EVANS. Thank you, Mr. Chairman.

Chairman SMITH. Thank you,

Mrs. Miller.

Mrs. MILLER. Thank you, Mr. Chairman.

Thank you all for being here, I know it is a long day, and for taking the time to testify.

My home state of West Virginia is about as rural as you can get, and there are so many patients that have to drive up to five hours to get medical care. Either they are driving to it themselves or their caretaker takes them just to get the care that they need. That is what makes home health care so important. And where clinically appropriate, it is an absolute game changer for my constituents.

The technology available today makes it common sense to me that we try and make health care available to patients in their own home, where they are most comfortable. This not only helps patients access care more easily, but it also lessens the burden that the caretakers have of, you know, having a job outside of their own loved ones, you know, having to take care of them.

One group of patients that I work particularly closely with, and are those with end stage renal disease, patients with ESRD typically have to dialyze at least three times a week just to manage their disease. In rural America, that can amount to hours upon hours. It can take your whole day, really, because you are traveling back and forth. You spend three or four hours doing it and, you know, it is hard, it is exhausting. That is why I am such an advocate for home dialysis. The ability for patients to dialyze at home reduces that burden of travel, and it allows the patients to work a full-time job if they want to, or go to school and still manage their own health care.

Mrs. Maddux, I am a mother and a grandmother, and I know what it is like to have your hands full and your darling children. But I didn't have any health problems like you have, and the complications. And hearing your testimony and how you juggled being a mother, and having a full-time job, and having to commute three times a week just to receive your dialysis is extraordinary to me, because I know what it was like not having a problem. And I am

sorry that that was your reality. I applaud your strength and the grace that you have shown, and how you have been taking care of your own health, as well as your family simultaneously. And I see them there, back there, shaking their heads.

As a patient who dialyzed in-center and now at home, can you compare the experiences? Tell us what was most difficult about making the transition to dialyzing at home?

Mrs. MADDUX. Being in-center, as I mentioned, there were many different parts of it that was very difficult. A lot of the patients, they were very ill, and sort of didn't want to be there. So the experience of going to in-center, compared to going at home, the impact on your emotional health and your mental health is indescribable. And you can't really calculate that.

And I also think that having that emotional impact and that mental health impact does have an impact on your health, as well. When you feel better about what you are doing, you feel better. And so with being at home, I was able to see an improvement in my health from that standpoint.

And then there was also the sense of autonomy and control that you regain of your own life. And that also has a positive impact on how you are feeling about things and how you feel. So that transition has multiple aspects of it that were an improvement on my life.

Mrs. MILLER. And even your disposition, because you are not feeling guilty, and you are more at ease of being in control of something that you weren't in control of, especially with the little ones that you don't have to take that deep breath before you answer because you are cool and you are calm.

I am working on a bill with Congressman Blumenauer that aims to increase access to home dialysis by providing trained, professional staff assistance to patients in their home. And the bill will ensure that all patients are given the education and the support that they need to utilize home dialysis, if they so choose.

I am glad to hear that staff training helped you to be able to dialyze at home, and I am hopeful that my bill will help provide coverage for these services to more ESRD patients. Mrs. Maddux, share what your experience was like navigating Medicare coverage for your training and dialysis at home.

Mrs. MADDUX. It was definitely a huge learning experience for me, and a lot that I had to learn on the fly and through trial and error. I learned that Medicare is required for people who are on dialysis for a period of time. So even though I maintained my health care coverage and my main health care—sorry, my main insurance coverage through my employer, I was still required to have Medicare.

And then I learned that I had to, you know, pay a premium for that coverage, even though it wasn't my choice.

I also learned that I had to maintain that coverage in order to stay active on a transplant waiting list.

So these are all things that I had to figure out as I went. There is a financial coordinator that is available, but she wasn't able to help me with filing paperwork, visiting the SSA office, waiting in line, being online on the telephone to just get all of that sorted out.

So it was a difficult experience, but I understand why I had to do it.

Mrs. MILLER. And it had to have been scary. It had to have been. And then, for you to finally reach that again, that deep breath of, okay, I am just going to follow through and get this done. I thank you for your answers and for sharing your story and your family.

And I hope to introduce the Improving Access to Home Dialysis Act very soon to help patients access this at home, and, Chairman, I yield back. Thank you.

Chairman SMITH. Mr. Panetta.

Mr. PANETTA. Thank you, Mr. Chairman. Thank you, Mr. Feenstra, for letting me go real quick. But thank you, Mr. Chairman, for having this hearing, and thanks to all the witnesses.

This hearing, for me, really highlights a number of issues that affect my constituents. In California's 19th congressional district, we face a convergence of high health care costs, provider scarcity, and a high rate of government insurance, all of which have really kind of created a perfect storm for providers and for patients, and pushed access out of reach for many people that I represent. That is why I have repeatedly, be it in this committee room or outside of it, raised the issue of costs which stretch providers that impact care, health care, in my district.

Now, Mr. Altchek, in your testimony you stated that Medicare reimbursement or remote patient monitoring, RPM reimbursement, based on geography, I think you said something to the effect of it is antiquated, but you also said it disincentivizes the adoption of home health services, especially in rural areas where payments are lower.

You go on to say, though, that your services have led to a 23 percent average decrease in a cost of care. So Mr. Altchek, have Medicare payment limits kept pace with these savings?

And as seniors make up a larger share of the population, how do you see telehealth, home health, and RPM services playing a role in the growth of Medicare?

Mr. ALTCHEK. Congressman Panetta, thank you for the question. I think there is two important policy considerations on Medicare.

The first is reimbursement rates for remote monitoring broadly have declined 28 percent since they were introduced in 2018. That is compared to nine percent decrease in broader Medicare rates via the conversion factor. If we want a health care future that is modern, we need to invest in it.

Number two, reimbursement in rural communities is substantially lower, 20 to 30 percent lower, than it is in urban communities because of the geographic differences. The cost to deliver the service is equal, whether it is in a rural community or an urban community. And we should just fix that. It is common sense policy.

And then number three, to your to your point about how—what role this plays, we have a dramatic access challenge today, as you mentioned, in your district. That problem is only getting worse, and exponentially worse, given the rapid increase in elderly population in the U.S. that is very chronically ill. So we have no choice but to embrace these technologies.

Mr. PANETTA. Now, obviously, when it comes to providers, my constituents, like I said, are facing a shortage. And the failure of Medicare to keep up with the cost of care, including the fact that Medicare Advantage payment rates for home health care have dropped by nearly a third, combined with the high cost of living, especially in my district, and the high rate of government-payer patients all make it harder year after year to recruit and to retain a health care workforce.

Now, when it comes to care by providers either at the office or by home, we need to work to ensure that Medicare is paying a substantial rate, but also that providers are maintaining standards of care. Mr. Altchek, how can CMS establish better measures to ensure patients continue to receive quality care under home health so we know that Medicare's investment is actually leading to better patient outcomes?

Mr. ALTCHEK. Yes, it is a great question. And I think the opportunity here is actually not to meet the existing standard of care, but what we are trying to do is elevate the standard of care. And I think we can do a dramatically better job in the U.S., especially with outcomes for patients with chronic disease.

The metrics that matter, you know, the good thing is that the CMS in the new shared savings metrics is really focused on a few key goals: A1C control, blood pressure control. We know the metrics that matter. I think all the physicians are aligned there. The question is, can we do a much better job of getting patients to control, which—the technology shows that it is able to do that.

Mr. PANETTA. I hope so. I got to go vote.

Mr. Chairman, thank you, I yield back.

Mr. FEENSTRA [presiding]. I now recognize Representative Beth Van Duyne.

Ms. VAN DUYNE. Thank you very much, Mr. Chairman.

With over 800,000 people living with end stage renal disease, which requires patients to undergo dialysis to survive since their kidneys can no longer filter their blood and remove toxins on their own, the patients need to be treated for roughly three to five hours at a medical facility, or they can opt to do home analysis four to seven times per week. Every step possible must be taken to allow a patient to get this lifesaving organ quickly and safely.

So last June I introduced the Saving Organs One Flight at a Time Act, which requires the TSA and FAA to issue regulations that would offer common-sense reforms to improve the air transportation of human organs. After September 11, 2001, the terrorist attacks in our nation, the ability for human organs to fly above the wings in commercial aircrafts was removed, causing organs to fly in the cargo hold, which has created confusion, delays, and even the destruction of these organs. And that is why I am also working to introduce a bill that would add the ability to automatically refer donors to organ procurement organizations, which should lead to the increased chance of a successful donation. I look forward to introducing this bill in the next coming weeks, and working across the aisle to help patients in need.

We have had a lot of people who have asked you questions. A lot of them have been multiple questions. When you get all the way down to the end of the dais and you have got, like, freshman mem-

bers of this committee, we are looking over our questions and, like, that has been asked, like, five times. So while I do have a number of questions that I could ask and make you all repeat yourselves, what I would prefer to do is at this point in time, what are some of the points that you feel, like, haven't been made that you would like to respond to that you perhaps didn't have an opportunity to respond to?

Mrs. Maddux, I am going to ask you to go ahead and go first.

Mrs. MADDUX. Thank you so much for asking that, and also thank you so much for your work.

I think that one thing that we haven't covered is trained staff. And a lot of the issues that we talked about with, for example, you know, traveling—health care provider traveling along distance to get to their patient. If we had more people and more staff who were trained in these modalities, I think that that would solve a lot of those issues. With the home dialysis training facility that I am working from, there is only one person who is doing the training and all the administrative work.

But I think that outside of, you know, innovations and technology, and outside of the other areas that we have discussed today, one thing that we haven't touched on is just training and having more prepared and well-trained staff to facilitate these different modalities.

Ms. VAN DUYNE. Excellent. Mr. Underhill.

Mr. UNDERHILL. I was asked earlier the cost of this treatment relative to cost in the hospital, and I have—as a patient, of course, I have no idea. So the lack of transparency, lack of ability to get that information is a concern to me.

Ms. VAN DUYNE. All right. Dr. Starr.

Dr. STARR. Thanks for that question.

The point that came to mind was one that was briefly mentioned before, and that is the ability of these telehealth and hospital-at-home programs to keep care and revenue for that care locally within some of these facilities and hospitals that are struggling so much financially.

You know, every patient that we keep locally is revenue that can then support the overall facility and benefit every member of that community.

Ms. VAN DUYNE. Excellent. Thank you.

Mr. ALTCHEK. Very quickly, I believe American health care is desperately in need of more innovation. And I can't underestimate—or understate the role that policymakers have in enabling that to happen. Obviously, this is a bipartisan issue, but the support from Congress makes a meaningful difference in these technologies becoming a reality.

Ms. VAN DUYNE. Anything in particular, though?

Mr. ALTCHEK. Medicare reimbursement sets the tone for Medicaid, for commercial. And so making sure Medicare reimbursement is aligned with where—with your vision for where health care should go is where we need to focus.

Ms. VAN DUYNE. Other than just, though, adding additional dollars, which is typically what, when folks come to our office, that is what they ask for, is there anything?

Mr. ALTCHEK. I think the big one is actually not adding additional dollars, it is making sure the geographic adjustment factor for Medicare takes into consideration the fact that technology costs the same, whether it is in a rural community or an urban community. And I think we need to fix that going forward to make sure that we level the playing field between these communities.

Ms. VAN DUYNE. Excellent. Thank you.

Dr. MEHROTRA. I want to build off one point that Dr. Starr made before, which is about licensure.

I don't know—Mrs. Maddux is—you are currently listed at three transplant centers, you said. And for patients in your position to go to clinicians who are in different states is very, very difficult right now because of the licensure rules. And so this is a major barrier to care for patients who want to get the care, the specialty care that they need, because the clinician in the other state can't care for them in their home state. So any reforms in that area would be critical.

Ms. VAN DUYNE. Thank you very much.

And I yield back.

Mr. FEENSTRA. Thank you. Now I recognize myself. I want to thank the panel for all that you have said and what you are working on.

I want to thank Mrs. Maddux for your comments. Truly inspiring, especially when you have children. I have children, too. And the challenges, you know, just being a mom, and then also dealing with your health.

And same thing with Mr. Underhill. Thanks for your comments and your thoughts and what we can do better. And that is what I want to address.

So I am from rural Iowa. I have 36 counties. And this is probably the number one issue right now, is rural access to care. And I see this on an ongoing basis, from EMS to maternal health care to just finding a doctor, a clinic to take care of patients. And so this is really outside-the-box thinking. And I think of Dr. Starr, Mr. Altchek, what you are talking about, is normalizing this type of care when it comes to telehealth, when it comes to hospital at home, when it comes to dialysis at home.

But the problem is, when you really step it down to rural, all right, there is a disconnect, right? Because I do hear about it. I hear from our hospitals, "If we could do more of X," what you are just doing. So Mr. Starr, Mr. Altchek, what are solutions to getting it to that next level?

I get it. Medicare and Medicaid are big problems, but it just seems like there is still a disconnect to creating the solution of what we want to normalize this care. What are your thoughts on that?

Dr. STARR. Yes, part of it is just time. It is still so new. Like somebody mentioned, you know, we had 10 years of innovation in 18 months during the pandemic. And I think everyone is still catching up to that, and recognizing that this—it is pretty revolutionary, what we are trying to do with care compared to what has been done the last 50 years. So part of it is getting comfortable with it.

But part of it is also having health systems and, you know, overall, as a society, recognize that, you know, some of this care is needed, it is transformative. The return on investment is going to be there, but it is not going to be for 20 years.

Mr. FEENSTRA. That is right, and it is innovative. But the return on investment—but that is what we have got to look at, the return on investment.

Mr. Altchek.

Mr. ALTCHEK. I would just say that the thing that we found to be successful is engaging local primary care doctors. We work with 800 local primary care doctors in rural and underserved communities. They want to do what is best for the patients. When given the technology they adopt it. The issue is how do we get the technology in their hands with a business model that they can support. But if we do that, the demand is there, as you mentioned, and you see in your district.

Mr. FEENSTRA. Yes. Well, thank you for that. I have to go vote, but I would like to—I will yield back, but I would like to thank the witnesses for appearing here today.

VOICE. Just recess, because Mr. Smith is coming back.

Mr. FEENSTRA. Okay, I guess we are going to recess, then. So the committee will take a brief recess, and we will be back shortly.

[Recess.]

Chairman SMITH [presiding]. The committee will come to order. Thank you all. We had to do something called voting on the House floor, and we worked that through.

We will go to Dr. Murphy.

Mr. MURPHY. Thank you guys for your patience today. This is our world, and it is insane. Why did I leave medicine, right? Why did I leave medicine to join this insanity? Well, it is because our country and medicine are a mess. So anyway, thank you all for coming. I had a specific question I wanted to ask.

First, what happened to our lady on the left? Did she leave? I will ask her when she comes back.

I want to ask, I guess, Dr.—pardon me, Mehrotra? There we go. Thank you, sorry. I was reading your testimony here, and I actually had asked Dr. Ferguson, if I was not here, to do this. I wanted to follow up on some of the studies and some of the statements that you made in your testimony. I ran a surgical practice for many years until I literally had to resign just to join Congress, and I was the one who was there at Saturday night at 2:00, counting the paper clips to make sure that we saved as much money to make payroll. Our payer mix is 74 percent government, Medicare and Medicaid, no insurance. And so literally, to survive we had to make sure that payments were done and we saved money where we could.

I was reading in here, when you were talking about telemedicine, which—telemedicine is critical for our practice, because I see patients two hours north, two hours south, and sometimes five hours out east. It was absolutely a lifesaver. And I mean literally a lifesaver during the pandemic to be able to do this.

I fully believe that we should not step down in any of this, because in rural America, we—first of all, everybody doesn't have gas money to get out to see physicians, and it is absolutely critical. I

don't believe the doc on the clock kind of thing, on the video thing spitting out weight loss medicines is good medicine, I believe it is absolutely poor medicine.

But I want to go back to one of the things you said. I know maybe Dr. Ferguson brought it up, that you recommended payment for telehealth visits to be less than in-person. Let me tell you what that would do to a practice, to a private practice. It would absolutely decimate it because patients want it, and I believe it is an absolute wonderful thing. If I am seeing a patient back who has had a prostatectomy and they are coming back for a PSA visit, that is absolutely a wonderful thing to do to save them, you know, it could be two hours on one end, two hours back.

But there is capital. There is an investment in a building, there is an investment in your nursing staff, in your malpractice, and everything. None of that goes away. And you have also invested 30—I invested now 35 years of my life in medicine with not only academia, but expertise in the field.

To say to Medicare, to say to insurance companies that that value of the knowledge that I deliver is less just because I am on a screen, rather than talking to somebody in person is wrong. It is absolutely flawed because those expenses still go. And if we want to be able to—in this world of a shortage of physicians, which is not getting any better—recent studies show that 63 percent of medical students do not plan on practicing clinical medicine. Our medical schools are doing an absolute failing job in delivering people into a workforce that is now terribly short. But then to then push people into further debt so that they close their private practices and either retire or go into hospital employment, which I know for a fact is less quality medicine, is absolutely wrong.

So I just have to say that. I don't care what studies show, because these studies were done outside of any real-world medicine. But this is factually inaccurate. Okay? I just, I have to say that. I speak from the real world. I take care of people that don't look like I do. And the expenses that—how many times I did not take a paycheck because we couldn't answer the expenses, or couldn't come up with the expenses.

Now, with the United Healthcare debacle, this is literally—while they get to keep their money, and they are making money on their money, this is absolutely wrong. So I just have to bring that out. We can't practice medicine, and CMS is doing this. It also absolutely countermands the whole great gift we have of telemedicine. I would not do it if you are going to lose money on it. Why would you do that? Why would you do that? You want to put something through.

I just want to say, Mr. Underhill, I am glad that experience worked out well for you. I am a little wary. Are we only talking about literally IV antibiotics and vital sign monitoring when people go home? Because you are surely not going to give patient-instructed narcotics or any type of cardiac medication. Are you guys talking about doing anything else?

Dr. STARR. Yes, so pretty—we can do a pretty broad range of therapies safely. Narcotics are a huge issue, and we don't do any IV narcotics. We do some limited oral, but IV diuresis, you know,

a variety of infectious treatments, IV fluids, you know, symptom control, you know, nausea and so forth we can all do.

Mr. MURPHY. Yes, you know, I think of people coming in with a catheter who are in retention and having post-obstructive diuresis. If they can literally just drink, they are in a good spot to be at home.

I am a big fan of this. It just has to be, we have to know the conditions into which we are delivering our patients, and have to understand that renumeration models are going to be critical. This cannot cost the system more than what it is costing now, because we are on a pathway to, you know, a desert with our money right now.

So I thank you all for doing this. It is way too late and it is past its time. But now with the technology that we have, it is going to be a lifesaver, and it is going to hopefully cost [sic] a lot of people money.

So thank you, Mr. Chairman, I will yield back.

Chairman SMITH. Thank you.

Mr. Moore.

Mr. MOORE of Utah. Thank you, Mr. Chairman. Thanks for holding this important hearing today to hear from patients, providers, and stakeholders on innovative ways to bring care to patients at their home. This is particularly important as Congress considers the expiring Medicare telehealth flexibilities and the hospital-at-home waiver this year.

I am excited to welcome Dr. Nathan Starr from Intermountain Health today to speak to their work in expanding patients' access to care in particularly rural and underserved areas. Intermountain is a Utah-based health care system, and yet another illustration of how Utah leads the nation in finding innovative and outcomes-based solutions to our various communities' challenges.

My team and I have heard from several folks back home, ranging from the Rural Health Association of Utah to primary and specialty care providers, about how telehealth flexibilities and the hospital-at-home waiver are enhancing their ability to provide care to patients from Saint George to Logan, and everywhere in between. And this is an important discussion today because, you know, as miserable as the pandemic was, and confusing as it was for people like—you look in the business community, and folks were able to find certain avenues and lanes to play in that they could be more flexible and, you know, we got through it. And I think we need to make sure that health care is doing the same. We came up with opportunities.

Dr. Starr, you and I have spoken. I have got four young kids. My wife is very busy, especially with me being gone so much. Finding these telehealth opportunities for ailments or conditions that could be solved if she has the flexibility to do this, I mean, there is real work that can be done here.

To my colleague from North Carolina, doing it right, doing it safe is key, and I know that Intermountain and many of the others are focused on that.

Dr. Starr, Intermountain has several telehealth programs aimed at expanding access to specialty care in rural areas of the state and throughout the Intermountain West region. Can you discuss what

those programs look like for patients, as well as how you balance in-person versus virtual care?

Dr. STARR. Yes, thanks for that question. The feedback we have gotten from patients has been really positive. And having done a lot of virtual care myself, it is really fun to be able to tell a patient, "If we brought you up to our quaternary center in Salt Lake City, I would take care of you. And I am telling you we can do the exact same things we would do here down there. You are going to get the exact same care," and that is incredibly reassuring.

The other thing we see all the time is many of these patients who live in rural areas don't want to leave. We have heard many times, "I would rather die than go up there and have to deal with all that." And so the fact that we can care for them where they are in place is hugely powerful and impactful.

Mr. MOORE of Utah. And would you say that it encourages folks to be more involved in their health care if it is more easily accessible?

Dr. STARR. Oh, definitely.

Mr. MOORE of Utah. Right, and we all talk about the performance of preventative health care, right? And getting out ahead of issues before they become catastrophic, or before you are in an ER. And, you know, I view this as an opportunity to continue to double down or double our efforts to encourage patients to change, right? You know, providers can do everything they can, but patients and—we have to change, the society has to change, and we have to be more willing to. And if that barrier is safe and lower for us to get that care, it is key.

You know, we have talked also, on the flip side of the coin, is the workforce shortages in health care, especially in rural and underserved areas. How can telehealth or remote patient monitoring expand the capacity for rural facilities to serve more patients?

Dr. STARR. Yes, we have seen some great examples of that, some of it mentioned, you know, with remote patient monitoring allowing a provider to see more patients.

Additionally, we have done a lot of work with nursing and providing not only, you know, tele-support for physicians and patients, but actually having a nurse program where inexperienced nurses can reach out and get support if they are not sure how to manage a patient—again, trying to make them as comfortable as possible and improve their job as much as we can.

Mr. MOORE of Utah. Mr. Altchek, anything to add to that?

Mr. ALTCHEK. I think your emphasis on preventative medicine is key, and what we have found is when patients actually start checking their vitals regularly and knowing that there is a nurse on the other side seeing the results, they take a lot more personal accountability for their care. So I think you are exactly right. This is not only a technology opportunity, but it is an opportunity to get patients more invested in their own health, which will have dramatic impact.

Mr. MOORE of Utah. Members of this committee are obviously very interested in ensuring taxpayers' dollars are utilized properly. You know, we are the stewards of Medicare's program finances, make sure that health care services improve patient outcomes.

Dr. Starr, just lastly, as we wrap up, can you talk about how Intermountain measures the value and quality of telehealth or other at-home services?

How does this differ from in†person care for similar services?

Dr. STARR. Yes, the way we measure it is really we don't look at revenue we bring in at all. It is all about cost savings, which makes it challenging. Our telehealth program runs in the red significantly if you just look at net operating income. But when we look at that value we create and the costs that we save in terms of transfers, keeping patients in their community, improved outcomes, the value is there.

Mr. MOORE of Utah. Excellent. Thank you all. Thank you to the patients, providers, everyone. I appreciate your thoughtful testimony today. And know that we are all partners here to try to get costs to a point where they are not so difficult for our constituents, and find solutions like this. I know you all are very much working on it.

Chairman, thank you.

Chairman SMITH. Thank you. I would like to thank our witnesses for appearing before us today, and also point out that Mrs. Maddux, our witness, had to actually leave early to do her dialysis. So that is how important this hearing is all about.

But please be advised that members have two weeks to submit written questions to be answered later in writing. Those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned.

[Whereupon, at 2:24 p.m., the committee was adjourned.]

MEMBER QUESTIONS FOR THE RECORD

MICHELLE STEEL
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COMMITTEE ON WAYS AND MEANS

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COMMITTEE ON STRATEGIC COMPETITION BETWEEN THE UNITED STATES AND THE CHINESE COMMUNIST PARTY

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March 12, 2024

Questions for the Record from Representative Michelle Steel (R-CA)
House Committee on Ways & Means
Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Telehealth has been a lifeline for so many in communities that have had challenges accessing care. Families and Seniors without access to a car, or who live far from medical facilities, or who are at high-risk of getting sick, can utilize telehealth as their best option for receiving immediate non-emergency care.

Last year, I re-introduced the Telehealth Expansion Act with Representatives Brad Schneider, Adrian Smith, and Susie Lee that would allow working class Americans, who have HSA-qualifying HDHPs, to have access to telehealth and other remote care services on a pre-deductible basis. I commend the Chairman and my colleagues across the aisle here for supporting the Telehealth Expansion Act when it passed the Committee last year. Without a permanent fix, more than 33 million Americans will lose this safeguard, especially as we get closer to the December 31 deadline.

In addition, patients with limited English proficiency are less likely than other Americans to make use of telehealth. I believe unclear communication can result in real harm to patients and providers. I introduced the SPEAK Act with Representative Jimmy Gomez which would create a taskforce to identify how best to support the over 25 million people in the U.S. with limited English proficiency and ensure they can also benefit from new health services.

Also, with workforce shortages, I believe we must improve access to telehealth in underserved and rural populations covered by Medicare and Medicaid. For those seeking care from CHCs, FQHCs, or RHCs, wait times for specialty care have grown to 58 days. It is anticipated that these wait times will continue to increase, ultimately comprising patient health and increasing costs for patients and their families as well as the overall cost to the health care system.

Recently, I introduced the EASE Act with Representatives Susie Lee, Mike Kelly, and Darin LaHood which would use existing CMS innovation center funds to expand virtual specialty care for populations in underserved and rural communities.

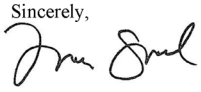
Questions for the Panel:

Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

Questions for Dr. Starr and Mr. Altchek:

With numerous telehealth, hospital at home, and other remote care service flexibilities expiring at the end of the year, could you elaborate how a failure to act on these policies until the last minute may negatively impact your business model in providing access to care for patients?

Sincerely,



Michelle Steel
Member of Congress

To complete the record for the Committee on Ways and Means March 12, 2024, hearing entitled, Enhancing Access to Care at Home in Rural and Underserved Communities, please respond to the attached Questions for the Record (QFRs).

Question

Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

Response:

Because I live near several large university research hospitals, I personally have only occasionally experienced inordinate delays in care due to staffing shortages. The delays I have experienced were in new surgical procedures that would not be available through telehealth. However, my regular screenings, such as for skin cancers, certainly would be more available through telehealth options.

Delay in health care is now such a part of our life experience that we accept it as normal. Logically, increasing telehealth options, where appropriate, would help alleviate the workforce shortage in health care, as well as reducing the time and travel cost to the patients.

Roy Underhill
Panel Member

MICHELLE STEEL
45TH DISTRICT, CALIFORNIA
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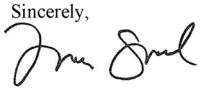

Michelle Steel
Member of Congress

Dr. Nathan Starr Responses to QFRs from Representative Steel

Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

This is a significant problem for most healthcare systems, including Intermountain Health. These workforce shortages include nurses as well as physicians. Telehealth has the opportunity to support shortages of both. We often see that rural hospitals hire new nursing graduates or those with less experience, as those are the applicants they receive. We have piloted having experienced medical and ICU nurses at our Telehealth command center be available to support nurses in real time who have questions, with great success. There are opportunities to expand this type of support.

For patients who need to see a specialist who live in rural areas, drive time is a major barrier as either the patient or provider needs to travel. Telehealth can eliminate this completely. In our experience, Telehealth offers the ability to provide high-level care, very efficiently. We do see that most tele interactions are shorter than in-person, and there is a skill to developing a rapport with patients virtually. The main downside is not being able to do a physical exam in person, however emerging technology is closing that gap and in conjunction with an on-site nurse or paramedic is very close to being in-person.

One major barrier to having success with both nursing and provider Telehealth programs is licensing. Being able to care for patients across state lines is very powerful. The licensing flexibilities afforded during the COVID-19 pandemic were tremendously helpful in enhancing access to care. We hope federal policymakers will seek to encourage such flexibility.

With numerous telehealth, hospital at home, and other remote care service flexibilities expiring at the end of the year, could you elaborate how a failure to act on these policies until the last minute may negatively impact your business model in providing access to care for patients?

Like many healthcare systems, Intermountain Health has invested heavily in care outside of hospitals and in the home, including Telehealth and Hospital at Home. We view Hospital at Home as a key part of our long-term strategy to manage inpatient hospital volumes. Since CMS is the largest payer for hospitalized patients, the Acute Hospital Care at Home waiver from CMS is the backbone of this program. It dramatically increased the number of patients eligible for Hospital at Home. Additionally, it provides the structure for approval from the State of Utah for Hospital at Home. Other payers, particularly for Medicare Advantage programs, rely on the waiver. The possibility that the waiver could end, or if it does end, would dramatically limit the scope of our Hospital at Home program. It would exclude many patients who benefit from and want this type of care and would force Intermountain Health to pivot and possibly reallocate resources away from needed areas to support bricks and mortar hospital expansion that could be avoided. We are supportive of a five-year extension of the current waiver.

Telehealth has allowed Intermountain to provide equivalent care to patients across the Intermountain West, who otherwise would be forced to travel long distances. As I noted in my written testimony about our Tele-Oncology program, we've had patients tell us they would likely not travel for Oncology care and would have died without the Tele-Oncology program. The current flexibilities have allowed our programs to scale, and we continue to be in a growth phase. We approach these programs financially from a value perspective. By keeping care local, we support local hospitals and communities. We save patients the cost and time of travel. We can better manage chronic diseases and avoid the cost of exacerbations of chronic disease. We also can more rapidly identify patients who require transfer to a higher level of care and get them to that appropriate level. Uncertainty in reimbursement and ability to provide this care virtually does cause hesitation for continued growth. Regulations limiting Telehealth are more concerning to Intermountain than reimbursement given our focus on value.

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March 12, 2024

Committee on Ways and Means
Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Nathan Starr, DO Medical Director, Home Services and Tele-Hospitalist Programs Intermountain Health

Caregivers have an incredibly important function in home-based services, particularly as we discuss shifting labor away from hospitals. As one of the primary caregivers for an aging parent in home, taking on these additional responsibilities is taxing – emotionally and physically.

Hospitals with these programs implementing hospital at home programs determine which services and which patients are eligible for the program, while also considering their own liability. This can limit access for historically marginalized communities, many of which would benefit from it most.

Dr. Starr, how does Intermountain determine who is a good candidate for the Hospital at Home program?

Are patients without caregiver support factored into the decision? How so?

Thank you,

Linda T. Sánchez

Dr. Nathan Starr Responses to Representative Sánchez

How does Intermountain determine who is a good candidate for the Hospital at Home Program?

We review multiple factors in a systematic approach. Overall, we always remember that we can take care of the patient in the hospital, and safety is our foremost consideration. First, we ensure that the patient meets inpatient criteria and needs hospitalization. This is because we want to exclude patients who would otherwise be discharged home. Second, we evaluate if we can provide the needed clinical care in the home with our resources. Third, we evaluate the risk of decompensation based on patient clinical factors including vital signs, laboratory values and diagnoses. Fourth, we evaluate patient mobility. Since we do not have someone in the home 24 hours a day, we make sure they have baseline mobility to be safe at home. Fifth, we ensure that the home is safe for our caregivers to go into. This includes toxin exposure (for example smoking meth in the home) as well as physical safety (guns, other members of household). Sixth, we evaluate the home for basic criteria including water, electricity and heat/air conditioning. Seventh, we make sure the patient has someone that we can talk to besides the patient. They don't necessarily need to be living in the same home, but they need to be willing to check on the patient if we cannot get hold of them. We try to be as flexible as possible to meet the patient's needs. That said, if we cannot safely care for the patient in their home, we will take care of them in the hospital.

Are patients without caregiver support factored into the decision? How so?

We recognize that not every patient has someone who lives with them, or can stay with them, yet they still want to be in their own home. We try to accommodate this using the criteria laid out above. We make sure that there is someone- family, friend, neighbor, tenant, landlord - who is willing to be a contact for us. If we cannot reach the patient, we can call that person and have them check on the patient. Importantly, if the patient lives alone, and has an outside the home contact, we are more cautious with our clinical criteria.

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Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

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Last year, I re-introduced the Telehealth Expansion Act with Representatives Brad Schneider, Adrian Smith, and Susie Lee that would allow working class Americans, who have HSA-qualifying HDHPs, to have access to telehealth and other remote care services on a pre-deductible basis. I commend the Chairman and my colleagues across the aisle here for supporting the Telehealth Expansion Act when it passed the Committee last year. Without a permanent fix, more than 33 million Americans will lose this safeguard, especially as we get closer to the December 31 deadline.

In addition, patients with limited English proficiency are less likely than other Americans to make use of telehealth. I believe unclear communication can result in real harm to patients and providers. I introduced the SPEAK Act with Representative Jimmy Gomez which would create a taskforce to identify how best to support the over 25 million people in the U.S. with limited English proficiency and ensure they can also benefit from new health services.

Also, with workforce shortages, I believe we must improve access to telehealth in underserved and rural populations covered by Medicare and Medicaid. For those seeking care from CHCs, FQHCs, or RHCs, wait times for specialty care have grown to 58 days. It is anticipated that these wait times will continue to increase, ultimately comprising patient health and increasing costs for patients and their families as well as the overall cost to the health care system.

Recently, I introduced the EASE Act with Representatives Susie Lee, Mike Kelly, and Darin LaHood which would use existing CMS innovation center funds to expand virtual specialty care for populations in underserved and rural communities.

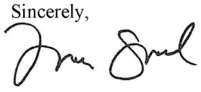
Questions for the Panel:

Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

Questions for Dr. Starr and Mr. Altchek:

With numerous telehealth, hospital at home, and other remote care service flexibilities expiring at the end of the year, could you elaborate how a failure to act on these policies until the last minute may negatively impact your business model in providing access to care for patients?

Sincerely,



Michelle Steel
Member of Congress

CADENCE

April 8, 2024

The Honorable Michelle Steel
Representative
United States Congress
1127 Longworth House Office Building
Washington, DC 20515

RE: Questions for the Record, House Committee on Ways & Means, Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Representative Steel,

Thank you for your extensive leadership on maintaining access to virtual care. Cadence appreciates your efforts to enable widespread access to telehealth, ensure that patients with limited English proficiency have these tools available, and make certain communities served by rural health clinics, federally qualified health centers, and community health centers can access virtual care. Please find answers to your questions below.

Questions for the Panel:
Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

C. Altchek, Cadence – Response:
The shortage of medical professionals is serious and worsening. According to the Association of American Medical Colleges, we will face a shortage of up to 40,000 primary care physicians by 2036.[1] The shortage is particularly dire in rural areas of the country, where poor access to care already shortens the lifespans of residents.

Remote physiologic monitoring (RPM) has emerged as a promising and cost-effective intervention to stem the tide of the growing physician shortage. Medicare enabled access to this form of at-home care between routine doctor's visits through the creation of new remote monitoring codes in 2018.

Cadence is at the forefront of providing RPM to rural and underserved communities, as approximately two-thirds of our patients live in these areas of the United States. RPM supports overburdened primary care clinicians by enabling virtual clinical teams to support local providers and extend their reach, increasing access for patients.

[1] AAMC, The Complexities of Physician Supply and Demand: Projections From 2021 to 2036, March 2024, https://www.aamc.org/media/75236/download?attachment.

95% of the physicians who order Cadence's RPM services are primary care providers who want to improve how they manage their patients' chronic conditions outside of the office visit, which can address some of the severe workforce shortages we see today. Cadence used detailed clinical protocols based on national guidelines and a team of highly trained nurse practitioners to deliver the highest quality of care. Our technology and team-based care model supports primary care providers who already lack the time to appropriately manage patients with chronic diseases.

This is particularly impactful for our patients with congestive heart failure. In many of the rural and underserved communities we support, wait times to see cardiologists are often longer than eight weeks. Cadence's congestive heart failure program has shown nationally-leading clinical outcomes, including 450% increase in patients achieving guidelines (i.e., GDMT).

The Cadence clinical team uses vitals data (e.g., blood pressure, heart rate, weight, blood glucose level) and the electronic medical record to adjust medications, order labs, and get patients onto the optimal care plan quickly and safely. Cadence staffs clinical team members 24 hours a day, 7 days a week, and 365 days a year to ensure timely care for patients with chronic and acute conditions and avoid unnecessary trips to the emergency room.

Questions for Dr. Starr and Mr. Altchek:
With numerous telehealth, hospital at home, and other remote care service flexibilities expiring at the end of the year, could you elaborate how a failure to act on these policies until the last minute may negatively impact your business model in providing access to care for patients?

C. Altchek, Cadence – Response:
While remote physiologic monitoring (RPM) is not subject to the same pandemic flexibility timeline as telehealth and other remote care services, any last-minute policy deters providers and hospital systems from investing in these high-value, evidence-driven services. Uncertainty in payment may disincentivize the adoption of RPM services, further increasing barriers to accessing quality care for patients living in rural and underserved communities. Cadence believes that a full suite of virtual tools is necessary to care for patients with chronic conditions – particularly those in rural and underserved communities.

Sincerely,
Chris Altchek

MEMBER:
COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON TAX
SUBCOMMITTEE ON TRADE
SUBCOMMITTEE ON SOCIAL SECURITY
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Linda T. Sánchez
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March 12, 2024

Committee on Ways and Means
Hearing on Ensuring Access to Care at Home in Rural and Underserved Communities

Chris Altcheck, Founder and Chief Executive Officer, Cadence

Home-based services hold promising benefits for Americans. They lend more flexibility and comfort for patients and their families, and seem to improve health outcomes, but more data is needed.

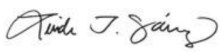
As we look into the possibility of expanding and extending some of these programs, we need to ensure that **all** communities can benefit from these programs. However, many low-income and rural communities do not have larger hospital systems in their area that have been able to build out these home-based services.

Mr. Altcheck, what are the up-front costs for a hospital that wants to invest in a remote patient monitoring program?

How can we help smaller hospitals make these investments?

Thank you,

Linda T. Sánchez



CADENCE

April 8, 2024

The Honorable Linda T. Sanchez
Representative
United States Congress
2428 Rayburn Office Building
Washington, DC 20515

RE: Questions for the Record, House Committee on Ways & Means, Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Representative Sanchez,

Thank you for your ongoing leadership to ensure better access to chronic disease care for all Americans. Please find answers to your questions below.

Question for Chris Altchek, Founder and Chief Executive Officer, Cadence:
Home-based services hold promising benefits for Americans. They lend more flexibility and comfort for patients and their families, and seem to improve health outcomes, but more data is needed.

As we look into the possibility of expanding and extending some of these programs, we need to ensure that all communities can benefit from these programs. However, many low-income and rural communities do not have larger hospital systems in their area that have been able to build out these home-based services.

Mr. Altchek, what are the up-front costs for a hospital that wants to invest in a remote patient monitoring program?

How can we help smaller hospitals make these investments?

C. Altchek, Cadence – Response:
High-quality RPM programs are expensive for hospitals to build on their own. Costs include significant investments in medical devices, logistics, software, connectivity, clinical labor, and program development. Our health system partners, which include leading academic medical centers and the largest health systems in the United States, selected Cadence after unsuccessful efforts to build in-house RPM programs due to the complexity and financial investment required.

Our approach at Cadence has several distinctive features that support an approach that integrates closely with primary care. Specifically, we have a nurse practitioner-led clinical team, a technology platform that is fully integrated with the ordering provider's electronic health record, 24/7 support available to patients, and technology that is seamless for older patients to use (especially in rural and underserved communities). This allows for a team-based, coordinated approach to a patient's physiologic data, safe and responsive titration of medications, and timely escalation to the appropriate care setting. These features have led to the significant positive clinical and cost-saving results in our data. Through this hands-on, tightly coordinated approach, Cadence ensures that primary care providers are able to identify and prioritize those patients who need their attention the most.

The most important policy consideration for enabling RPM in low-income and rural communities is to ensure adequate reimbursement under both the outpatient payment rules and physician payment rules. Smaller hospitals have limited resources to build new programs. In non-facility setting, RPM reimbursement has declined by up to 28% since 2019 (versus 9% for the Conversion Factor), which discourages these hospitals from making an investment:

	CF*	% Δ	CPT 99454	% Δ
2019	$36.04	-	$64.15	-
2020	$36.09	0%	$62.44	-3%
2021	$34.89	-3%	$63.16	1%
2022	$34.61	-1%	$55.72	-12%
2023	$33.89	-2%	$50.15	-10%
2024	$32.74	-3%	$46.49	-7%
2019-2024	**-$3.30**	**-9%**	**-$17.66**	**-28%**

* CF values reflect Final Rules and legislative adjustments, excluding the most recent congressional fix under the Consolidated Appropriations Act, 2024

In the hospital outpatient setting, RPM reimbursement is particularly low. Attached is a letter that Cadence sent to CMS in response to the final hospital outpatient payment rule requesting that hospital-based clinicians be able to bill the full suite of remote monitoring codes, as RPM is often a follow-on to hospital-based services.

You are correct that the costs of implementing a high-quality RPM program are significant, and while the patient benefits are clear, the financial decision to launch an RPM program can be

challenging. Costs include cellular or Wi-Fi enabled devices, responsive staff capable of addressing both clinical and device-related issues, as well as a sophisticated software platform that is able to collect and process large quantities of physiologic data. While we believe a broader push to value-based payment will support the adoption of RPM, these programs do not always provide an adequate incentive right now and Congress and the Administration must ensure that fee-for-service reimbursement supports the widespread adoption of these lifesaving services that lead to fewer hospitalizations and overall reduced health care costs.

Sincerely,
Chris Altchek

CADENCE

December 29, 2023

Administrator Chiquita Brooks-LaSure
Centers for Medicare & Medicaid Services
Department of Health & Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, D.C. 20201

RE: CY 2024 Hospital Outpatient Prospective Payment System Policy Changes and Payment Rates; CMS-1786-FC

Dear Administrator Brooks-LaSure:

Cadence appreciates the opportunity to submit comments in response to the Calendar Year 2024 Centers for Medicare & Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (OPPS) Final Rule. We provide remote physiologic monitoring (RPM) services to over 15,000 patients across 19 states through partnerships with national health systems.

In our comment letter to the Calendar Year 2024 CMS OPPS Proposed Rule (the "Comment Letter"),[1] we requested that CMS provide separate reimbursement for the RPM time-based treatment management codes performed by clinical staff, 99457 and 99458, under the OPPS the same way it does for the time-based chronic care management (CCM) code 99490. CMS denied this request, stating it "continue[s] to believe that, since CPT code 99457 primarily describes the work associated with the billing of professional services, which would not be paid separately under the OPPS, and CPT code 99458 describes an add-on service to CPT code 99457, neither service is appropriate for separate payment under the OPPS." 88 FR 81540, 81706. Unfortunately, this response appears to misconstrue the design of the RPM codes at issue and fails to address the disparity in treatment between the RPM and CCM codes.

We respectfully request that CMS reconsider its decision regarding separate reimbursement for CPT codes 99457 and 99458. CMS has designated 99457 and 99458 as care management codes. 85 FR 84472, 84544 ("We addressed who can furnish CPT codes 99457 and 99458 in the CY 2020 PFS final rule (84 FR 62697-62698) when we designated both codes as care management services."); *see also* 85 FR 84472, 84542 ("In this final rule for CY 2021, we continue our work to improve payment for care management services through code refinements related to remote physiologic monitoring"). **This means that these RPM codes, like other care management codes, can be billed by a hospital to the OPPS to receive separate**

[1] The Comment Letter is available at: https://www.regulations.gov/comment/CMS-2023-0120-3039.

reimbursement when the hospital's own clinical staff furnishes the services.[2]

Moreover, as shown in the graphic below, CMS explicitly recognizes separate reimbursement for care management codes under the OPPS in its billing guidance for CCM code 99490 (Frequently Asked Questions about Billing Medicare for Chronic Care Management Services, March 17, 2016, https://www.cms.gov/medicare/medicare-fee-for-service-payment/hospitaloutpatientpps/downloads/payment-chronic-care-management-services-faqs.pdf):

Hospital Outpatient Prospective Payment System (OPPS)

22. Are hospital outpatient departments (HOPDs) eligible to bill CPT code 99490 under the OPPS?

Yes, CPT code 99490 is payable under the OPPS when certain requirements are met (see details in question #23 on billing requirements). As CPT code 99490 is defined as a physician-directed service, the OPPS provides payment to the HOPD when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). Payment under the OPPS represents only payment for the facility portion of the service. Payment for the physician's (or other appropriate practitioner's) time directing CCM services in the HOPD setting is made under the PFS at the facility rate.

23. What are the requirements to bill CCM under the OPPS?

CPT code 99490 is a physician-directed service that is only payable under the OPPS when the hospital's clinical staff furnishes the service at the direction of the physician (or other appropriate practitioner). The billing physician or practitioner directing the CCM services must meet the requirements to bill CCM services under the PFS, when the CCM service is furnished in the physician office or the hospital outpatient department. A Fact Sheet on CCM including requirements to bill CCM services to the PFS is available on the CMS website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf.

In addition to CMS providing separate reimbursement under the OPPS for the CCM time-based management code 99490 when furnished by a hospital's clinical staff, CMS also provides separate reimbursement for other care management services when they are provided by the hospital's clinical staff: principal care management (PCM) services, behavioral health integration (BHI) services, and transitional care management (TCM) services. The following table describes all of these care management services and their associated reimbursement under the OPPS:

[2] We agree with CMS that RPM codes 99457 and 99458 can be used to describe the work associated with the billing of professional services, specifically, the billing practitioner's provision of, or the supervision of clinical staff's provision of, RPM services billed to the Medicare Physician Fee Schedule at the non-facility or facility rate, as applicable.

Code	Description	OPPS Payment	National Payment Amount	Ambulatory Payment Classification	Status Indicator
99457 + 99458	RPM management services performed by clinical staff – first 20 minutes and each subsequent 20 minutes	No	N/A	5012 (99457); 5741 (99458)	B
99490	CCM services performed by clinical staff – first 20 minutes	Yes	$75.85	5822	S
99426	PCM services performed by clinical staff – first 30 minutes	Yes	$75.85	5822	S
99484	BHI care management services performed by clinical staff	Yes	$29.68	5821	S
99495 + 99496	TCM services performed by clinical staff with face to face visit after 14 days or 7 days	Yes	$120.86	5012	V
Source: Addendum B, CMS, January 2024, https://www.cms.gov/medicare/medicare-fee-service-payment/hospitaloutpatientpps/addendum-and-addendum-b-updates/addendum-b.					

The above demonstrates that the RPM time-based codes, 99457 and 99458, are left out of the reimbursement equation for hospitals under the OPPS, disincentivizing hospitals from offering these valuable services to patients. Cadence data show that RPM reduces emergency department visits by 18% and decreases the total cost of care by 23% for patients with heart failure, hypertension, and diabetes. Unfortunately, CMS' decision prevents some of the most vulnerable patients from receiving RPM today. A decision by CMS to start reimbursing the RPM codes under the OPPS would be especially impactful for provider-based locations of hospitals that employ primary care providers.

Despite CMS' response to our Comment Letter, it is clear that even when codes may be used to describe physician-directed services reimbursable as professional services under the Medicare Physician Fee Schedule, those same codes may be used to provide payment to a hospital when their clinical staff furnishes the services. **RPM codes 99457 and 99458 should be treated like CCM code 99490 and the other care management codes referenced above.** We request that CMS reconsider its determination and rectify it in the upcoming OPPS proposed rule.

We appreciate your consideration. Should you have any questions about this submission, please contact Meryl Holt, Head of Legal, at meryl@cadencerpm.com.

Sincerely,

Christopher Altchek
Founder & Chief Executive Officer
Cadence

MICHELLE STEEL
45TH DISTRICT, CALIFORNIA
STEEL.HOUSE.GOV

COMMITTEE ON WAYS AND MEANS

COMMITTEE ON EDUCATION AND THE WORKFORCE

COMMITTEE ON STRATEGIC COMPETITION BETWEEN THE UNITED STATES AND THE CHINESE COMMUNIST PARTY

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March 12, 2024

Questions for the Record from Representative Michelle Steel (R-CA)
House Committee on Ways & Means
Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Telehealth has been a lifeline for so many in communities that have had challenges accessing care. Families and Seniors without access to a car, or who live far from medical facilities, or who are at high-risk of getting sick, can utilize telehealth as their best option for receiving immediate non-emergency care.

Last year, I re-introduced the Telehealth Expansion Act with Representatives Brad Schneider, Adrian Smith, and Susie Lee that would allow working class Americans, who have HSA-qualifying HDHPs, to have access to telehealth and other remote care services on a pre-deductible basis. I commend the Chairman and my colleagues across the aisle here for supporting the Telehealth Expansion Act when it passed the Committee last year. Without a permanent fix, more than 33 million Americans will lose this safeguard, especially as we get closer to the December 31 deadline.

In addition, patients with limited English proficiency are less likely than other Americans to make use of telehealth. I believe unclear communication can result in real harm to patients and providers. I introduced the SPEAK Act with Representative Jimmy Gomez which would create a taskforce to identify how best to support the over 25 million people in the U.S. with limited English proficiency and ensure they can also benefit from new health services.

Also, with workforce shortages, I believe we must improve access to telehealth in underserved and rural populations covered by Medicare and Medicaid. For those seeking care from CHCs, FQHCs, or RHCs, wait times for specialty care have grown to 58 days. It is anticipated that these wait times will continue to increase, ultimately comprising patient health and increasing costs for patients and their families as well as the overall cost to the health care system.

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Questions for the Panel:

Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

Questions for Dr. Starr and Mr. Altchek:

With numerous telehealth, hospital at home, and other remote care service flexibilities expiring at the end of the year, could you elaborate how a failure to act on these policies until the last minute may negatively impact your business model in providing access to care for patients?

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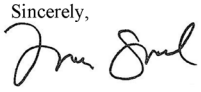

Michelle Steel
Member of Congress

Questions for the Record for Ateev Mehrotra, MD

House Committee on Ways & Means
Hearing on "*Enhancing Access to Care at Home in Rural and Underserved Communities*"
Committee Hearing on March 12, 2024

Thank you, Representative Steel, for the opportunity to respond to this question.

Before responding to your question, I want to echo your point that telehealth has been an important lifeline to care for so Americans over the last four years. I am concerned that the use of telemedicine in the Medicare program continues to fall because of the lack of a permanent policy moving. I also appreciate your proposed bills which will support the many who cannot currently access telemedicine including those in rural communities and those receiving care from CHCs and FQHCs.

I also wanted to clarify one point in my written testimony. I wrote that currently telemedicine reimbursement is lower than the equivalent in-person visit. That is not exactly right. While telemedicine visits provided by outpatient hospital physicians are paid less than the equivalent in-person visit (because there is no facility fee), in the office setting telemedicine visits for mental health treatment in are being reimbursed the same amount as an equivalent in-person visit.

Question. Today, our hospitals don't have enough medical professionals and there aren't enough people in the pipeline to take care of an aging population with more complex conditions. Wait times for accessing specialty care across the country are a growing problem. I have seen data that shows an average wait time of over 2 months for patients that primarily utilize health centers and rural hospitals. Is this a problem for participants on the panel and how can telehealth address the severe workforce shortages we see today?

Response: I agree access to specialty care of all types is a problem across the nation. These access barriers are larger for those receiving care at health centers and rural hospitals. Telehealth can help address this problem in several ways. Expanded access to telehealth will allow patients to access specialists who are physically far away. With permanent telehealth reimbursement, I hope health systems will invest in more infrastructure (e.g., telehealth hosting hubs) in rural communities to make it easier for patients to have their initial telemedicine visits. Legislation that addresses licensure barriers is also critical given so many people visit a specialist in a different state. Our research has found that the benefits

of expanding access to specialty care is highest for those receiving care in rural emergency departments. Unfortunately, these small hospitals are the least likely to have telemedicine. CFOs of these hospitals describe how the current reimbursement structure does not make starting a telehealth program financially sustainable. I believe we need programs to help financially support the initial infrastructure for these programs at small rural hospitals. Lastly, eConsults are another form of telehealth that has been shown to improve access to specialty care for underserved patients. Increasing use of eConsult programs is another promising way to improve specialty access. I am happy to provide more details on these programs if that would be helpful.

Thank you again for giving me the opportunity to respond to this question.

PUBLIC SUBMISSIONS FOR THE RECORD

On behalf of the National Kidney Foundation, the 37 million Americans with chronic kidney disease, (CKD), and the more than 800,000 Americans with end stage renal disease (ESRD), we write in strong support of policy solutions that help improve access to home dialysis.

Kidney Failure and Dialysis

Kidneys play an important role in maintaining health. They remove toxins from the blood, control the production of red blood cells, produce vitamins and hormones, regulate blood pressure, balance nutrient levels, and perform other important functions. When the kidneys fail, a person requires a transplant or dialysis to survive. Due to the shortage of donor organs for transplant, most people with kidney failure – more than 550,000 adults in America – require dialysis to replace their kidney function.

"*Dialysis is difficult…If it's not cramp, it's itching. There are times when I get cramps and …so, so painful. And then there are times when I feel so weak, I feel like a wilted vegetable. It's hard. Dialysis is hard.*"

\- Ron[1]

There are two types of dialysis. Hemodialysis (HD) is a process where a dialysis machine and a special filter are used to clean the blood. Doctors access the blood through an access point, usually in the patient's arm. Over the course of several hours, blood flows from the access point, through tubes to the dialyzer, where waste products are removed and washed away, before returning to the patient's body. A hemodialysis session typically takes three to four hours.

Peritoneal dialysis (PD) is a slightly different process where lining of the patient's abdomen is used as the filter. In PD, the abdominal area is slowly filled with dialysis fluid through a catheter. The fluid, also called dialysate, draws waste products out of the blood, through the membrane in the patient's abdomen, and are absorbed into the dialysate, which is then drained and discarded. PD can be done several times over the course of the day or can be performed overnight while the patient sleeps.

Home Dialysis in the United States

In the United States, most patients – approximately 85 percent -- receive hemodialysis that is provided in a dialysis center. In-center dialysis requires patients to receive treatments three to four hours a day, typically three days a week. This can be time consuming and taxing on the body. Patients often feel fatigued and washed-out after in-center dialysis, leaving them unable to work, drive, or enjoy recreation or leisure time with their families. Approximately 12 percent of patients receive peritoneal dialysis that they typically perform in their homes, and only about three percent of patients receive home hemodialysis. Patients who dialyze at home often have more flexibility around the duration, time, and frequency of their dialysis treatments.

Among the population receiving either home hemodialysis or peritoneal dialysis, there are stark racial and ethnic inequalities. Even though they only make up 13 percent of the population,

[1] https://usrds-adr.niddk.nih.gov/2023/end-stage-renal-disease/12-patient-experience-narratives-from-people-receiving-hemodialysis

African Americans make up 35 percent of in-center dialysis patients. Only 7.3 percent of African American and 7.4 percent of Hispanic or Latino patients receive home dialysis, compared to 9.4 percent of White patients. [2]

There are also significant geographic variations in access to home dialysis. Only approximately 50 percent of dialysis providers even offer home dialysis as an option and among those programs, most serve less than 20 home dialysis patients. Home dialysis utilization is higher in some rural areas, but still not adequate to meet demand.

Benefits of Home Dialysis

Home dialysis patients often experience improvements in quality of life, including, improved sleep, ability to consume a more "normal diet," and less time traveling to and from dialysis. Thanks to the improved quality of life, home dialysis patients are two to three times more likely than in-center patients to be employed[3]

Beyond quality of life, many patients on home dialysis experience better clinical outcomes. In one study, patients on home hemodialysis experienced better BP control, showed reduced inflammation, and enjoyed improved nutrition and better phosphorus control. Evidence also shows that patients on PD have better residual renal function, better circulation, and reduced risk of certain kinds of stroke[4]. Patients on PD have a 40 percent lower mortality rate than patients receiving in-center dialysis.[5]

Barriers to Home Dialysis

Many patients express a desire to dialyze at home, but often face barriers accessing home dialysis, including:

- Inadequate patient education
- Insufficient number of providers who offer home dialysis
- Staffing shortages that impede access to home dialysis training
- Inadequate staff assistance for home dialysis patients
- Misaligned reimbursement and quality incentives

The National Kidney Foundation has long supported policy solutions that address many of these barriers. Specifically, Kidney Disease Education (KDE) is highly effective in promoting informed dialysis selection, optimal dialysis starts, and home-dialysis use. Unfortunately, less than one percent of patients with kidney failure receive Medicare KDE prior to dialysis

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[2] Rizzolo, Katherine; Cervantes, Lilia; Shen, Jenny I.. Racial and Ethnic Disparities in Home Dialysis Use in the United States: Barriers and Solutions. JASN 33(7):p 1258-1261, July 2022. | DOI: 10.1681/ASN.2022030288

[3] https://www.dovepress.com/home-hemodialysis-a-comprehensive-review-of-patient-centered-and-econ-peer-reviewed-fulltext-article-CEOR

[4] Tang SCW, Lai KN. Peritoneal dialysis: the ideal bridge from conservative therapy to kidney transplant. J Nephrol. 2020 Dec;33(6):1189-1194. doi: 10.1007/s40620-020-00787-0. Epub 2020 Jul 11.

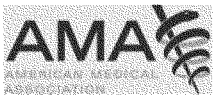
[5] https://www.healio.com/news/nephrology/20231017/turkish-study-shows-40-lower-mortality-for-patients-on-hhd-vs-incenter-dialysis

initiation. Current regulations restrict qualified health care professionals from delivering services and limits coverage to specific, finite settings. NKF believes that safe and effective care can be achieved by health care teams who are located outside of the same physician office setting, while also expanding beneficiary access to much needed services, in particular those beneficiaries who were limited to access because of challenges related to transportation, long commutes to physician offices, inflexible work schedules, and/or provider shortages.

We also support changes to the ESRD Conditions for Coverage to expand the types of entities who can offer home dialysis services. Current requirements are centered around the bricks-and-mortar dialysis model and impede innovation and proliferation of new provider access points. NKF supports efforts to update the CFCs to foster more innovation, create more flexibility, increase transparency and accountability, and create a more patient centric system.

Finally, NKF supports legislation that increase staff assistance and training for home dialysis. The draft *Improving Access to Home Dialysis Act of 2024* authorizes Medicare to cover trained, professional staff assistance for patients in the home and ensure that all patients are given the education and support they need to utilize this modality if they so choose. It would also work to reduce the backlog in training wait-times by utilizing telehealth and group training, where possible, and expand the roles of other care-team partners to address the nephrology workforce shortage. It also includes a patient quality of life measure for all dialysis patients and a study on the racial disparities in the utilization of home dialysis.

In closing, the National kidney Foundation applauds the Committee for its interest in this issue and stands ready to work on these policy proposals and other strategies to increase patient access to home dialysis.



STATEMENT

of the

American Medical Association

U.S. House of Representatives

Committee on Ways and Means

Re: Enhancing Access to Care at Home in Rural and Underserved Communities

March 26, 2024

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Statement for the Record

of the

American Medical Association

to the

Committee on Ways and Means

Re: Enhancing Access to Care at Home in Rural and Underserved Communities

March 26, 2024

The American Medical Association (AMA) appreciates the opportunity to submit the following Statement for the Record to the U.S. House Committee on Ways and Means as part of the hearing entitled, "Enhancing Access to Care at Home in Rural and Underserved Communities." The AMA commends the Committee for its consideration of this critically important issue aimed at, among other things, ensuring the continuation of certain programs and policy flexibilities granted as part of the response to the COVID-19 pandemic that help ensure patients retain access to at-home care. The COVID-19 pandemic made clear that rural and underserved areas that have historically lacked adequate access to health care services can greatly benefit from permanent legislative and regulatory flexibilities. As a result, we applaud the Committee for recognizing the importance of promoting health equity as it considers which COVID-19 policies to retain to facilitate continued access to home-based care. In addition, we urge Congress to consider how making many of these existing flexibilities permanent will provide the necessary assurances that physicians, health care organizations, and patients may need before investing additional resources into policies such as telehealth and the Hospital at Home program. Long-term or permanent extensions of policies that promote and enable at-home care will bring further value to the American health care system.

INNOVATION MODELS AND TECHNOLOGY

The AMA strongly recommends that Congress permanently lift the restrictions on access to telehealth services for Medicare patients by passing the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (S. 2016/H.R. 4189) and H.R. 7623, the Telehealth Modernization Act.

Introduced by Representatives Mike Thompson (D-CA) and David Schweikert (R-AZ) on the Ways and Means Committee, the CONNECT for Health Act is bipartisan legislation that would permanently extend many important COVID-19 telehealth flexibilities that have significantly improved access to care for patients in rural and underserved areas. More specifically, the bill repeals the existing Medicare geographic site restrictions and permanently modifies the originating site requirements to allow patients to receive telehealth services wherever the patient can access a telecommunications system, including, but not limited, to the home. These COVID-19 policies have allowed patients to obtain telehealth services at home instead of having to travel to a medical facility to receive virtual care from a distant site. They have also allowed Medicare patients located in urban and suburban areas to have access to telehealth services

for the first time. COVID-19 flexibilities also enabled patients to access health care services through audio-only visits when they do not have reliable access to two-way audio-video telecommunications technology. Therefore, passage of, the Telehealth Modernization Act (S. 3967/H.R. 7623), which was introduced by Senators Tim Scott (R-SC) and Brian Schatz (D-HI) in the Senate, and Reps. Buddy Carter (R-GA), Lisa Blunt Rochester (D-DE), Greg Steube (R-FL), Terri Sewell (D-AL), Mariannette Miller-Meeks (R-IA), Jeff Van Drew (R-NJ), and Joe Morelle (D-NY) in the House, is crucial because it permanently continues the ability to use audio-only telehealth services beyond the current statutory deadline of December 31, 2024. Access to two-way audio-visual telehealth and audio-only services has lowered or eliminated barriers that many patients in rural and underserved areas face when trying to obtain in-person care, such as functional limitations that make it difficult to travel to physician offices, long travel times, workforce shortages, the need for a caregiver to accompany the patient, and patients experiencing unstable housing and lack of transportation and childcare.

Permanently removing the antiquated geographic restrictions and modifying the originating site requirements means patients will no longer have to travel, counterintuitively, to a limited set of brick-and-mortar medical sites to access virtual care. In an effort to boost access to virtual mental health services, The Connect for Health Act also repeals the requirement within the Consolidated Appropriations Act, 2021, requiring patients to see a physician in-person within six months of an initial telehealth visit for a mental health condition. Federal lawmakers have also introduced stand-alone bills, specifically H.R. 3432/S. 3651, the Telemental Health Care Access Act, to remove these in-person visit requirements that will only stifle access to mental health services. While federal lawmakers have, thus far, passed legislation delaying the mandate for patients to receive an in-person visit within six months of receiving an initial telemental health service from taking effect, it is crucial this policy is permanently removed to ensure patients retain ample access to virtual mental health services. Absent Congressional intervention, the in-person telemental health requirements will go into effect on January 1, 2025, so it is crucial legislative action occurs expeditiously.

The dramatic increase in the availability of telehealth services has catalyzed the development and diffusion of innovative hybrid models of care delivery utilizing in-person, telehealth, and remote monitoring services so that patients can obtain the optimal mix of service modalities to meet their health care needs. These models can also reduce fragmentation in care by allowing patients to obtain telehealth services from their regular physicians instead of having to utilize separate telehealth-only companies that may not coordinate care with patients' medical home. Now, all Americans, including rural, underserved, minoritized and marginalized patients, can receive a combination of in-person and virtual care, which is crucial for patients with chronic diseases. Congress should not permit these flexibilities to expire as it will run counter to its goals of promoting more home-based care.

The AMA also strongly opposes any efforts to impose other types of antiquated "guardrails" pertaining to telehealth services. The AMA views telehealth as a method to deliver care, and creating significant burdens to access these services in the name of program integrity requires substantial justification. As a result, the AMA strongly opposes H.R. 1746, the Preventing Medicare Telefraud Act, or any other legislation that promotes similar policies.

This legislation requires a patient to receive an in-person visit within 6 months of receiving "high-cost" durable medical equipment (DME) and laboratory tests ordered via telehealth. This provision makes little sense as it is impossible clinically for a physician to know if the patient will need high-cost DME or laboratory tests prior to receiving a telehealth visit. Under this legislation, "high cost" DME and

laboratory tests would also be defined by the Centers for Medicare & Medicaid Services (CMS) Administrator, which the AMA believes to be an excessive expansion of executive authority.

In addition, H.R. 1746 stipulates that, beginning six months after the effective date of the high-cost DME/lab clause, Medicare Administrative Contractors (MACs) shall conduct reviews on a schedule determined by the HHS Secretary of all claims of high cost DME/lab tests ordered over the preceding 12 months when at least 90 percent of these services are prescribed by a physician/provider via telehealth. Again, since telehealth is simply a modality, the AMA believes such audits are not appropriate or necessary because it provides no consideration of medical necessity. Additionally, the percentage threshold could lead to some very odd results that could disproportionately impact smaller practices. Policymakers should consider a small practice only ordering nine out of 10 total "high cost" DME/Labs via telehealth. Under this bill's provisions, this would still trigger an automatic audit, which is excessive and unnecessarily burdensome.

In general, the AMA urges members of the Ways and Means Committee to reject any inclination to establish additional guardrails, including in-person visits or mandatory audits, in the name of rooting out fraud, waste, and abuse. The AMA believes these concerns are misplaced given CMS' existing tools for combating fraud and abuse, the increased ability telehealth services provide for documentation and tracking, and the lack of data to suggest that fraud and abuse or duplication of services are of particular concern for telehealth services.

The AMA believes existing HHS and OIG fraud capabilities and authorities are more than adequate to police telehealth services in the same way they oversee in-person Medicare services. A February 2024 HHS OIG report confirms this reality.[1] For 105 out of the 110 sampled Evaluation and Management (E/M) services provided via telehealth during the early parts of the pandemic, providers appropriately complied with Medicare requirements. As a result, OIG did not provide any policy recommendations to CMS because, "…providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments we identified resulted primarily from clerical errors or the inability to access records." Medicare fraud is still Medicare fraud, irrespective of whether it involved telehealth services. Additional restrictions do not currently apply under the Medicare Advantage, the Center for Medicare & Medicaid Innovation, section 1116 waiver authorities, the existing Medicare telehealth coverage authority, or other technologies such as phone, text, or remote patient monitoring.

In February 2021, HHS's Principal Deputy Inspector General (OIG) released a statement dispelling any concerns with OIG's authority or ability to address concerns of fraud and abuse. Instead, HHS OIG's statement highlights concerns stem from "telefraud" schemes, rather than "telehealth fraud," in which bad actors use "telehealth" as a basis for fraudulent charges for medical equipment or prescriptions which are unrelated to the telehealth service at issue. In those cases, fraudulent actors typically do not bill for the telehealth visit but instead use the sham telehealth visit to induce a patient to agree to receive unneeded items and gather their info. In other words, whether the telehealth service itself is covered has no impact on these kinds of fraudulent schemes.

Moreover, telehealth services may prove even easier to monitor for fraud and abuse because of the digital footprint created by these services, state practice of medicine laws requiring documentation of these services, and the ability to track their usage with Modifier 95. CMS has also implemented Place of Service

[1] https://oig.hhs.gov/oas/reports/region1/12100501.asp.

(POS) indicators for this purpose, including POS 02 when the originating site is someplace other than the patient's home and POS 10 when the patient is in their home. Additional indicators may be used for asynchronous services and home health services provided via telehealth. Telehealth services are even more likely to have electronic documentation in medical record systems than in-person services. Practice of medicine laws in all 50 states permit physicians to establish relationships with patients virtually so long as it is appropriate for the service to be received via telehealth. In addition, two-way audio-visual services can be effectively deciphered and tracked by CMS via Modifier 95 and other CMS indicators. The Modifier 95 describes "synchronous telemedicine services rendered via a real time Interactive audio and video telecommunications system" and is applicable for all codes listed in Appendix P of the CPT manual. Modifier 95 and the POS indicators are applicable for telemedicine services rendered through December 31, 2024. The requirement to code with Modifier 95 and POS enables CMS to properly decipher and track telemedicine services, thus improving the chances of identifying and rooting out fraud, waste, and abuse.

Acute Hospital Care at Home Waiver Program Extension

In addition to telehealth, the Ways and Means Committee should consider extending flexibilities that permit the continuation of the hospital-at-home program. On March 11, 2023, the AMA along with other organizations, including medical groups participating in the Acute Hospital Care at Home (AHCaH) waiver program, submitted a request to Congress asking for at least a five-year extension of AHCaH before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to AHCaH programs that have demonstrated excellent clinical outcomes and lower the costs of care. With an expiration set for the end of this year, medical groups and health systems nationwide need assurance that this waiver program will be extended if they are going to invest their resources into logistics, supply chain, and workforce for AHCaH. A five-year extension can also help ensure hospital inpatient unit care is available for the patients who need it while enabling patients who can and want to be treated in their home to have the opportunity to do so, creating needed capacity for hospitals without increasing health system costs.

The State of Health at Home Models: Key Considerations and Opportunities

Building on existing playbooks and resources supporting digitally enabled care, the American Medical Association conducted research to explore the different ways health care is and can be provided in the home. The AMA report titled, "The State of Health at Home Models: Key Considerations and Opportunities" offers a comprehensive guide that outlines the concept and benefits of delivering care to patients in their home environments.[2] These include recommendations to:

- Determine whether your practice or organization should build your health at home program internally or partner with another organization.
- Consider required training to strengthen your mobile workforce, which is a core component of health at home programs.
- Ensure you understand the unique and varied circumstances of each home environment and plan for the patient and caregiver experience in detail.
- Develop the infrastructure up front that will provide the necessary tools to appropriately handle the flow of resources and information to provide patient care as required by your specific program.

[2] https://www.ama-assn.org/system/files/health-at-home-models.pdf.

Future of Health Case Study: Atrium Health

This case study highlights how this vision is being accomplished through a strategic partnership between a traditional brick-and-mortar health system and a technology company, with a common goal to build and scale a program that enables patients to continue their care and recovery at home. Each organization brings its expertise to the partnership, enabling thoughtful development and implementation of a complex, digitally enabled clinical initiative.

Payment and Delivery in Rural Hospitals

In this issue brief, the AMA reports on background, challenges, costs and strategies related to the delivery of care in rural hospitals. Additionally, this includes strategies to improve rural health and hospital viability.

ASPE Report - Updated Medicare FFS Telehealth Trends by Beneficiary Characteristics, Visit Specialty, and State, 2019-2021

This report by the Assistant Secretary for Planning and Evaluation (ASPE) reveals sustained above-pre-pandemic levels of telehealth utilization among Medicare beneficiaries, notably for behavioral health and primary care visits. This sustained utilization highlights the importance of telehealth in bridging access gaps, particularly for vulnerable populations due to the severity and complexity of their illnesses. The findings from ASPE highlight the critical role of telehealth in maintaining continuity of care and suggest a pressing need for policies that support the permanent integration of telehealth services within the Medicare program.

AHRQ Study - The Impact of Expanded Telehealth Availability on Primary Caree Utilization

An Agency for Health Care Research and Quality (AHRQ) funded study analyzing over four million primary care encounters highlights telehealth's role in maintaining health care utilization levels without contributing to overutilization. This study's results challenge concerns about potential increased health care utilization due to telehealth expansion, reinforcing telehealth's value as a viable alternative to in-person encounters when deemed appropriate. Given these insights, it is important for legislation like the CONNECT for Health Act and the Telehealth Modernization Act to pass, ensuring telehealth's role as a cornerstone of accessible, efficient health care delivery.

In light of the ASPE report and AHRQ-funded study findings, telehealth has been instrumental in maintaining access to essential health care services, especially during challenging times. The data supports permanent removal of geographic and site restrictions on telehealth services, as proposed by the CONNECT for Health Act and the Telehealth Modernization Act. By making these telehealth flexibilities permanent, Congress would be taking a significant step towards a more inclusive, accessible, and efficient health care system that is capable of meeting the needs of all patients, regardless of their geographical location or socioeconomic status.

Change Healthcare and Cybersecurity

The attack on Change Healthcare in February 2024 is a stark reminder of the critical importance of cybersecurity in health care. Change Healthcare, a division of UnitedHealth Group, was struck by a

ransomware attack that significantly disrupted the largest health care payment and operations system in the United States. This incident led to widespread disruptions, affecting thousands of medical practices, hospitals, pharmacies and others. Despite efforts to recover from this attack, the impact on health care operations was profound, including the disruption of claims processing, payments, and electronic prescriptions leading to financial strain on physicians, hospitals and pharmacies, and delays in patient care.

In fact, on March 19th, Representatives Mariannette Miller-Meeks (R-IA) and Robin Kelly (D-IL), along with 96 bipartisan members of the House of Representatives, sent a letter to HHS Secretary Becerra alerting the administration of the ongoing challenges physicians and patients are continuing to experience as part of the Change Healthcare cyberattack. In addition to highlighting the inability of physician practices to file claims and receipt prompt payment, the letter urges CMS to clarify why they issued such stringent repayment terms as part of their March 9th announcement permitting advance payments for Part B physicians and other providers. The letter also highlights how individuals are being forced to pay out-of-pocket for pharmaceuticals and health care services due to the cyberattack, as well as pressed the Department for answers as to how it proposes to safeguard patients from the negative impact of their private health care information being inappropriately disclosed to malicious actors.

Overall, the attack demonstrates the vulnerability of our health care sector's infrastructure to cyber threats and the cascading effects these breaches can have on patient safety, privacy, and the overall delivery of care. The health care sector's reliance on interconnected digital systems for patient records, billing, and payments, means that the impact of a cyberattack can be both immediate and widespread, affecting patient care and operational continuity.

This incident is especially concerning for rural, remote, and underserved communities, where access to health care services is already limited. The reliance on digital platforms for telehealth and at-home care programs has been a lifeline for these communities, offering a measure of parity in access to essential health care services. However, the cybersecurity vulnerabilities exposed by the attack on Change Healthcare reveal a potential gap in our efforts to extend health care equity through digital means. As noted in the March 21st letter led by Vice Chairman Vern Buchanan and 19 Ways and Means members, a 2022 AMA study found that nearly 75 percent of patients expressed concern about protecting their personal health data.

The technical and financial burden of implementing cybersecurity should not be placed solely on physicians or the hospitals. Congress must provide important financial resources to assist physician practices with the challenge of protecting health care data. Ensuring the security of digital health care services is not merely about protecting data but about safeguarding the continuity of care for the most vulnerable populations in our society.

ELECTRONIC FUND TRANSFER (EFT) FEES AND REDUCING ADMINISTRATIVE BURDENS IN HEALTH CARE

The AMA recognizes the critical need to address financial and administrative inefficiencies that detract from our health care system's ability to serve rural and underserved communities effectively. A pressing issue in this context is the undue financial strain imposed on physicians and health care providers by unnecessary fees for Electronic Fund Transfers (EFTs).

The burden of EFT fees, as outlined in our support for H.R. 6487, the "No Fees for EFTs Act" in the House, and support for S. 3805, the corresponding Senate bill, highlights a significant barrier to the efficient operation of health care practices. These fees, which can range from two percent to five percent of the claim payment, are levied by some health plans and their vendors without explicit agreement from practices, thereby exacerbating the administrative burdens on physicians. This issue is especially significant for health care providers in rural and underserved areas, where financial resources are already stretched thin, and administrative burdens can significantly impact the quality and accessibility of patient care.

By eliminating these predatory fees, the "No Fees for EFTs Act" would make a substantial contribution toward reducing administrative complexities, allowing physicians to allocate more resources towards patient care rather than navigating financial obstacles. This legislative action is particularly crucial in supporting the sustainability of telehealth and Hospital at Home programs, which have become vital in bridging the health care access gap in rural and underserved communities.

Furthermore, the administrative burden associated with managing EFT fees detracts from the time and attention health care providers can dedicate to patient care, including providing more services at home. In an era where every resource should be directed toward enhancing patient outcomes and accessibility, it is counterproductive to allow such financial inefficiencies to persist. As a result, we urge the Ways and Means Committee to exercise its jurisdictional authority over this issue and expeditiously pass this bill so physicians can devote more resources to things like investment in telehealth and other forms of at-homecare, which will bend the overarching cost curve of health care in the United States.

SUSTAINABLE PROVIDER AND FACILITY FINANCING

Need for an Inflation Based Update to Physician Payment

The physician payment system is on an unsustainable path that threatens patients' access to physician services. This year, physicians faced yet another round of real dollar Medicare payment cuts triggered by the lack of any statutory update for physician services tied to inflation in medical practice costs and flawed Medicare budget neutrality rules. Congress acted this month to partially mitigate the 3.37 percent reduction that was imposed in January but did not stop the cuts completely. These cuts come on the heels of two decades of stagnant payment rates. Adjusted for inflation in practice costs, Medicare physician payment rates fell 29 percent from 2001 to 2024 because physicians, unlike other Medicare providers, do not get an automatic yearly inflation-based payment update.

In its 2023 annual report, the Medicare Trustees "expect access to Medicare-participating physicians to become a significant issue in the long term" unless Congress takes steps to bolster the system. The Trustees noted, for example, that "the law specifies the physician payment updates for all years in the future, and these updates do not vary based on underlying economic conditions, nor are they expected to keep pace with the average rate of physician cost increases."

The current Medicare physician payment system—with its lack of an adequate annual physician payment update—–is particularly destabilizing as physicians, many of whom are small business owners, contend with a wide range of shifting economic factors when determining their ability to provide care to Medicare beneficiaries. Physician practices compete against health systems and other providers for staff, equipment, and supplies, despite their payment rates failing to keep pace with inflation. In fact, the

government's measure of inflation in physicians' costs, the Medicare Economic Index (MEI), rose 4.6 percent.

We appreciate that Congress passed legislation that, again, mitigated severe Medicare payment cuts. However, this pattern of last-minute stop gap measures must end. As the Committee looks to provide adequate payments to physicians, particularly those in rural and underserved areas, annual Medicare physician payments equal to the full MEI should be enacted to provide an annual update that reflects practice cost inflation.

We urge lawmakers to consider the pressing need for adequate payments to physicians. Specifically, we ask Congress to pass H.R. 2474, the "Strengthening Medicare for Patients and Providers Act," which provides a permanent annual update equal to the increase in the MEI. Such an update would allow physicians to invest in their practices and implement new strategies to provide high-value, patient-centered care and enable CMS to prioritize advancing high-quality care for Medicare beneficiaries without the constant specter of market consolidation or inadequate access to care.

Improvements to Budget Neutrality

Another way to help ensure physicians have ample resources to provide more care in the home is via reforms to statutory budget neutrality requirements within the Medicare Physician Fee Schedule. The AMA urges the Ways and Means Committee to pass H.R. 6371, the Provider Reimbursement Stability Act. In fact, the Energy and Commerce Committee already took action on a portion of this legislation when it passed H.R. 6545, the Physician Fee Schedule Update and Improvement Act, out of committee in December 2023.

The reality is that physician payments are further eroded by frequent and large payment redistributions caused by these budget neutrality adjustments. CMS actuaries have on occasion overestimated the impact of Relative Value Units (RVUs) changes in the fee schedule. When these misestimates are not adjusted in a timely way, it results in permanent removal of billions of dollars from the payment pool. Given the statutory authority for budget neutrality adjustments to be made "to the extent the Secretary determines to be necessary," current law allows CMS to account for past overestimates of spending when applying budget neutrality. Congress should consider requiring a look-back period (as have been implemented in other payment systems) that would allow the Agency to correct for misestimates and adjust the conversion factor to reflect actual claims data.

In addition, the $20 million threshold that establishes whether RVU changes trigger budget neutrality adjustments was established in 1989—three years before the current physician payment system took effect. There have been no adjustments for inflation. As a result, the amount should be increased to $53 million to best account for past inflation.

Merit-based Incentive Payment System (MIPS)

Since the enactment of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the AMA has worked closely with Congress and CMS to promote a smooth implementation of MIPS. We supported MACRA's goals to harmonize the separate, burdensome, and punitive Meaningful Use, Physician Quality Payment System, and Value-Based Payment Modifier programs. However, the implementation of a new Medicare quality and payment program for CMS and physicians has been a significant undertaking, which was drastically disrupted by the COVID-19 pandemic. Further refinements are urgently needed to achieve the goals of MACRA and reduce the administrative burden for physicians. Worse, there is a growing body of evidence that the program is disproportionately harmful to small, rural, safety net, and independent practices, as well as devoid of any relationship to the quality of care provided to patients.

Last year, the AMA responded to a Congressional RFI request from the House Committee on Ways and Means' on ways to improve health care in rural and underserved areas. In our comments, we highlight the difficulties experienced by health care providers, particularly small, rural, independent, and safety net practices, in adapting to the MIPS framework, especially in the context of the disruptions caused by the COVID-19 pandemic. We also proposed three key legislative changes aimed at mitigating the negative impacts of MIPS penalties, improving the timeliness and relevance of performance feedback and claims data provided by CMS, and making the program more clinically relevant while reducing the administrative burden on practices. We urge Congress to continue considering these recommendations and look forward to collaborating closely on these critical issues to ensure that health care providers, especially those in rural and underserved areas, are supported effectively through the MIPS framework.

Private Equity and Health Care

The increasing presence of private equity in the health care sector raises important considerations for the sustainability and accessibility of health care services. With a notable shift in physician practice ownership from independent practices to those owned by hospitals, health systems, and private equity groups, there is an urgent need to examine the implications of these changes, especially in rural and underserved areas where health care options are already limited. Rural and underserved communities stand to be significantly impacted by the growing influence of private equity in health care. These areas, already grappling with a shortage of health care providers and limited access to medical services, may find themselves further marginalized by health care consolidation and the business-driven approaches of private equity-owned practices.

The AMA's observation of a decline in the percentage of physicians working in private practices highlights the potential for decreased health care autonomy and personalized patient care, aspects crucial for addressing the unique health challenges of these communities.The AMA supports legislation which creates a more equitable and transparent health care system that prioritizes patient care over profit. The aforementioned H.R. 2474 is one such proposal that seeks to ensure sustainable Medicare physician payment rates, a crucial factor in maintaining the viability of independent practices and, by extension, preserving access to high-quality health care in rural and underserved areas. Additionally, addressing systemic issues such as physician burnout, escalating practice expenses, and the administrative burdens of regulatory compliance are essential steps towards stabilizing the health care landscape. Legislative efforts such as MIPS improvements and prior authorization reforms can alleviate some of the pressures driving physicians towards private equity and other alternative ownership models.

CONCLUSION

The AMA is committed to working with Congress to find permanent solutions that ensure that Medicare beneficiaries have uninterrupted continued access to high quality, affordable health care which includes virtual care and care delivered in the home setting. We must build on the gains achieved during the pandemic so that all patients regardless of their zip code have access to the care they need.

ConnectedHealthInitiative

March 26, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
Washington, District of Columbia 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
Washington, District of Columbia 20515

RE: Statement for the Record of Brian Scarpelli, executive director of the Connected Health Initiative, on the hearing *Enhancing Access to Care at Home in Rural and Underserved Communities*

Dear Chairman Smith and Ranking Member Neal:

Thank you for holding this hearing on the opportunities and challenges in enhancing access to care in patients' homes and modernizing care in rural and underserved communities. Digital medicine will be key to enhancing access to care and ensuring patients in rural and underserved communities can receive the attention they need. As the COVID-19 public health emergency (PHE) demonstrated, digital health and telemedicine modalities allow for flexible and timely healthcare delivery, as long as patients and doctors can use the method most accessible to them. They do not lead to increased fraud or over-utilization. I urge you to expand flexibilities for digital health and allow patients to find the care they need.

The Connected Health Initiative (CHI) is a coalition of healthcare stakeholders from all across the value chain, from patient and provider groups to research universities and software and device companies. We advocate for policies that enable these stakeholders to harness the power of technology to spur patient engagement, improve health outcomes, and control costs. All our members agree that access to digital healthcare benefits not only patients, but providers as well.

Pandemic-era flexibilities for digital healthcare tools and services

During the PHE, the Department of Health and Human Services (HHS), under its emergency authority, provided much-needed flexibilities for providers and patients in several key areas to facilitate efficient and efficacious care. Patients were able to take telehealth appointments from their homes, reach their doctors more easily online, and take up innovative remote monitoring tools and services with far fewer hurdles (including no copay). From providers' perspective, numerous outdated restrictions on digital health capabilities were set aside, such as through Centers for Medicare & Medicaid Service (CMS) enabling a supervising professional to be immediately

available through a virtual presence using real-time audio/video technology instead of being physically present. Across providers and patients, the experience of the PHE illustrated the untapped potential of digital health tools to improve outcomes and save costs across a range of use cases, and how legacy restrictions in statute and regulation are dashing that potential without benefit to the public. With the PHE now expired, we call on Congress and HHS to take the steps needed to fully enable these digital health tools to advance the Quadruple Aim.

Congress has already taken important steps in response to the country's COVID-19 PHE experience that can and should be built on. Thanks to this Committee's work and both chambers prioritizing the issue, restrictions over a quarter of a century old in Section 1834(m) of the Social Security Act, which blocked Medicare coverage of live audio and video visits except in rather narrow circumstances and disallowed access to those services from a patient's home, have been temporarily lifted through the end of 2024. We have long supported the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act (H.R. 4189) as well as the Telehealth Modernization Act (H.R. 7623). Both bills would permanently unlock Medicare coverage for live audio / video visits, including visits conducted at the home of patients. Virtual care is now mainstream. People in rural and underserved areas benefit most from being able to visit with their caregivers virtually and they are a major reason why Section 1834(m)'s restrictions must be permanently eliminated. Similarly, the PHE flexibilities allowed for coverage of audio-only telehealth services, recognizing that a video component requirement unnecessarily impedes access to care for individuals without reliable internet access and disproportionately harms rural and underserved populations. Flexibility for audio-only telehealth services was extended to the end of this calendar year, but we encourage its permanent extension.

The WEAR IT Act

To further the adoption of digital medicine and improve rural healthcare, CHI supports H.R. 6279, the Wearable Equipment Adoption, Reinforcement, and Investment in Technology (WEAR IT) Act, led by Congresswoman Michelle Steel. The WEAR IT Act would allow individuals to access certain wearable health technology through their tax-advantaged flexible spending accounts (FSAs) and health savings accounts (HSAs). Currently the IRS allows HSA and FSA funds to be spent primarily on single-purpose devices. In a recent development, the IRS now considers the Oura Ring and the Aura Pulse Comprehensive Health Tracker eligible for FSA and HSA expenditures, two exceptions to the IRS's general rule against such devices. Many cutting-edge wearable health devices have multiple functions such as catastrophic fall detection, heart rate monitoring, and/or blood oxygen measuring. Although these devices outperform covered legacy technology in many cases, they are generally not covered (with the exceptions described above) because of the IRS's historical interpretation of the law, which is outdated. The IRS has recently begun to modernize its approach to HSA and

FSA eligibility, but only in unpredictably narrow cases. If Congress enacts the WEAR IT Act, patients, consumers, and providers will benefit from greater certainty that such devices will be covered by FSAs and HSAs. In turn, healthcare stakeholders will have more choice and additional ways to improve outcomes and control costs. Moreover, the use of wearable health technology in rural and underserved settings will help patients and providers by collecting more detailed information that can improve treatment, especially for chronic conditions. This could be life-changing for patients who live far from their doctors.

Remote physiologic and therapeutic monitoring

Remote monitoring tools and services allow great flexibility for patients to access their care. One member of CHI, Avenue Health, demonstrates the potential of remote monitoring every day. Nurses employed by Avenue Health remotely monitor patients with conditions like hypertension, and patients can call these nurses when they are feeling poorly. Access to remote monitoring and instruction from these nurses reduces emergency visits by patients, saving the health system money. This care at home—or wherever a patient experiences an issue—is a key means of care for rural communities in particular. Many more patients could benefit from this type of monitoring for a variety of chronic and acute conditions.

We applaud the positive step taken in last year's Medicare and Medicaid Physician Fee Schedule (PFS) to allow remote monitoring at Rural Health Centers (RHCs). This move prioritizes remote care at RHCs, where it can be especially useful for patients and providers. However, several barriers impede the wider adoption of remote monitoring innovations already shown to improve outcomes, reduce costs, and augment providers' experience. For example, remote monitoring services are subject to the 20 percent copay required for Medicare coverage. Too many Medicare beneficiaries are unable to afford a monthly bill for remote monitoring, even if it may greatly benefit their health. Notably, during the PHE, HHS waived this requirement and others; responsibly expanding patient access in this way leads to better management of chronic conditions, ultimately saving money in Medicare expenditures. Over three years of digital health usage during the PHE showed that, without legacy restrictions that have little or no public benefit, it is being used responsibly and appropriately.

The copay requirement one of many outdated restrictions still in place that no longer has a connection to public benefit. Eliminating arbitrary barriers like this would help more providers see the benefit of remote monitoring and increase innovation. CHI members already work to innovate in the healthcare sector, but bureaucratic barriers stop them from reaching their full potential.

Utilization of telehealth services

Digital medicine and telehealth services are a clear value add to all healthcare, but especially in rural areas. Studies have consistently demonstrated that telehealth services are not more susceptible to fraud than in-person healthcare, and that including telehealth services does not lead to over-utilization. According to the Alliance for Connected Care, telehealth usage in Medicare currently accounts for about 5 percent of services, a number which has remained steady since the start of the PHE. Even with the addition of telehealth usage, the overall usage of Medicare services has not increased significantly. Restricting telehealth services due to fears of over-utilization will just mean that rural areas continue to lack access to key healthcare supports.

CHI understands that addressing waste, fraud, and abuse is a key goal for the Committee as you look at Medicare spending. We agree that tackling these issues will help bring down the overall costs of healthcare spending, but we stress that telehealth has proven no more prone to fraud than other healthcare modalities. It is important to distinguish between telehealth fraud, the perpetration of healthcare fraud using telehealth modalities, and "telefraud," the use of telemarketing to defraud consumers, including healthcare consumers. This second type of fraud is better addressed through existing authorities at the Federal Trade Commission (FTC). This February, the HHS Office of the Inspector General (OIG) released a report examining the incidence of telehealth fraud in Medicare and found that the telehealth services provided to Medicare beneficiaries did not show signs of fraud. We urge the Committee to focus on some of the other concerns highlighted in this testimony rather than spending scarce resources attempting to curtail fraud that is shown not to exist in significant quantities.

Conclusion

Addressing issues in rural healthcare is vital to ensuring a system that benefits all patients. Digital health technology, including wearable and remote monitoring technology, can make a huge difference for individuals and patient groups as a whole. CHI urges the adoption of policies that allow for flexibility to innovate and provide the care that patients need.

Sincerely,

Brian Scarpelli
Executive Director
Connected Health Initiative

ADVOCATE HEALTH

PO Box 32861
Charlotte, NC 28232-2861

advocatehealth.org

March 12, 2024

The Honorable Jason Smith
Chairman, Committee on Ways and Means
United States House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

Submitted electronically via WMSubmission@mail.house.gov.

RE: Enhancing Access to Care at Home in Rural and Underserved Communities Written Submission

Dear Chairman Smith:

We appreciate the opportunity to submit a written statement for consideration by the Committee and for inclusion in the printed record for the Enhancing Access to Care at Home in Rural and Underserved Communities hearing. We applaud the Committee's efforts to address the unique challenges that continue to impact rural communities and the health care providers who serve them. As you have noted in the past, patients in rural areas face many difficulties in accessing health care, including longer travel distances, longer wait times, and limited availability of certain specialty services. Rural residents suffer from higher drug overdose rates, decreased life expectancy, higher rates of multiple chronic conditions, and increased prevalence of obesity. Rural residents are also more likely to delay care, ultimately leading to higher emergency department utilization and longer in-patient hospital stays.

Health care workforce shortages and hospital closures further diminish access to high-quality, affordable care in rural communities. Recent studies show that 25% of rural hospitals are at high risk of closing, and hospitals that are not integrated into a broader health system can be more vulnerable to shuttering.[1] Enhancing care access and improving health outcomes for our rural communities will require tailored solutions, the leveraging of innovative technologies,

[1] [1] *See* Guidehouse, "Rural Hospital Sustainability Index Analysis: Trends in Rural Hospital Financial Viability, Community Essentiality, and Patient Outmigration, *available at* https://guidehouse.com/insights/healthcare/2022/rural-analysis.

and efforts that ensure the economic viability of rural health systems and providers in the long term.

We offer our written submissions below for the Committee's consideration to help inform solutions to rural care challenges. As one of the largest providers of rural health care in the Midwestern and Southeastern United States, we look forward to sharing our experiences with the Committee and working together to achieve a health care system that better serves our rural communities.

About Advocate Health

Advocate Health is a not-for-profit integrated health care system serving nearly six million patients annually. Headquartered in Charlotte, North Carolina, we provide care under the names Advocate Health Care in Illinois, Atrium Health in the Carolinas, Georgia and Alabama, and Aurora Health Care in Wisconsin. Wake Forest University School of Medicine serves as the academic core of Advocate Health. We provide care across more than 1,000 sites of care – many of which are located in rural areas. We serve more than one million rural patients annually across our health care enterprise. We employ more than 155,000 health care professionals, including more than 21,000 physicians and 42,000 nurses. Our health systems are an important source of employment in the areas in which we operate, contributing to the economic vitality of the broader community. We have made significant investments in redesigning the health care delivery system to address the specific challenges and needs of our rural patient population, and we are committed to engaging in partnerships that will continue to expand our rural footprint.

Virtual Care at Advocate Health

Advocate Health is extending its reach and its ability to improve health, elevate hope and advance healing for all through its advances in virtual care. Access to virtual care is particularly important in rural communities. As rural residents must travel farther distances and are more likely to delay care than their urban counterparts, making care more convenient and accessible is essential to preventing crisis episodes and keeping patients healthy. Deploying virtual care solutions in rural communities enhances patient access to care, improves patient experience, lowers the overall cost of care, and improves outcomes. Recognizing this vital link to our rural patient population, Advocate Health has invested significantly in providing safe, timely, and effective virtual care.

Our virtual care platform – Virtual Edge – is one of the largest and most comprehensive virtual care platforms in the nation. We take great pride in offering our rural providers frictionless access to a suite of 30 key virtual health services, and we provide more than 300,000 rural

care virtual visits annually, including hospital care, critical care, specialty services, and remote patient monitoring. Our virtual platform enables us to provide necessary care to patients who may not otherwise be able to access it.

With the opioid public health emergency still disproportionately affecting rural populations, access to behavioral health care is extremely important in our rural communities. Roughly half of all counties in the United States lack a practicing mental health professional, and this shortage can be even more pronounced in rural areas. For example, 48 counties in North Carolina have either no or only one practicing psychiatrist, and most of these counties are rural. Our virtual care platforms enable us to address these critical shortages, incorporating behavioral health expertise into the primary and acute care settings. This integrated access to behavioral health care helps us intervene before a patient experiences an acute crisis – significantly reducing emergency department visits, avoidable hospital days, and hospital readmissions.

Atrium Health Hospital at Home Program

Atrium Health's signature virtual platform is the Atrium Health Hospital at Home program. In just three years, it went from the drawing board to being what is believed to be the largest hospital at home program in the nation. Our virtual Hospital at Home program has been successful in providing hospital-level care to patients in the comfort of their homes, helping to avoid costlier and unnecessary in-patient hospital stays. Atrium's Hospital at Home program was started in March 2020 in response to Covid-19's impact on a surging patient population in the Charlotte area. The original purpose for starting the program was because of capacity management challenges exacerbated by the pandemic. Even today, our hospitals run well over 100% occupancy because there are simply not enough beds. Home-based care offers a solution to ongoing capacity issues, with an innovative way to care for a growing population of older and sicker patients. To date, we have seen close to 10,000 patients in our program. This has saved close to 33,000 inpatient days in our facilities, freeing up much needed bed space. Our Hospital at Home patients report a 14% higher patient experience score compared to traditional hospital settings.

While the program was initially geared towards COVID-patients not needing hospital level care, the program has now expanded, from 10 to 40 community paramedics who work together with 14 nurses dedicated to hospital at home, and six providers – such as physicians and advanced practice providers (nurse practitioners or physician assistants) – who provide care at home, treating conditions from acute to chronic condition exacerbation and even post-surgical. We treat over 130 different conditions in our program. By directly observing patients in the home, paramedics can also assess additional needs, such as food insecurity or social challenges that may affect overall health and connect them with the appropriate resources. Essentially, the home-based patient is treated and discharged like an inpatient.

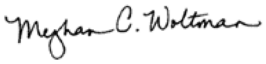
Overall, this model is here to stay, and the advantages of such a program are clear. Even though we are building new facilities, we will continue to need more beds. As the population grows and ages, we expect virtual health care services will be in greater demand. It is being embraced by people of all ages because of the convenience, the ability to access care on demand and the chance to avoid sitting near sick people in a physician's waiting room. Widespread acceptance and use of the model can slow the inflationary growth of health care costs for consumers over time. Inpatient hospital care will always be needed, but if home-based care is appropriate, it reduces the risks of falls, hospital acquired infections, and other concerns. **Given the many benefits of providing hospital-level care at home, the waivers that enable these programs should be made permanent.**

Conclusion

We are happy to discuss our responses and our successful rural home care strategies with you and your staff in more detail as the Committee continues these important efforts to improve rural home health care access and outcomes. If you have any questions or need any additional information, please do not hesitate to contact: Meghan.Woltman@aah.org.

We look forward to working together to implement policies that support innovative technologies to ensure that rural residents have better access to care when they need it and closer to home.

Sincerely,



Meghan Woltman
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Advocate Health

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Statement of ChristianaCare
Committee on Ways and Means
United States House of Representatives

Submitted for the record: "Hearing on Enhanced Access to Care at Home in Rural and Underserved Communities."

March 12, 2024

Submitted electronically via email to: WMSubmission@mail.house.gov

ChristianaCare, one of the nation's leading not-for-profit health care delivery systems headquartered in Wilmington, Delaware, appreciates the opportunity to comment to the House Committee on Ways and Means regarding the important topic of enhancing access to care at home in rural and underserved communities.

ChristianaCare includes an extensive network of primary are and outpatient services, home health care, urgent care centers, three acute care hospitals, a freestanding emergency department, a Level I trauma center and a Level III neonatal intensive care unit, a comprehensive stroke center and regional centers of excellence in heart and vascular care, cancer care, and women's health.

At ChristianaCare, we are committed to serving our neighbors as expert, caring partners in their health through the creation of innovative, effective, affordable, and equitable systems of care. ChristianaCare shares your dedication to further improve our health care delivery system and applauds your readiness to identify solutions to ensure patients continue to have access to services across the continuum, including care provided in the home.

Acute Hospital Care at Home Waiver Program

Launched in late 2021,[1] ChristianaCare's Acute Hospital Care at Home program (AHCaH) offers the highest level of in-home acute care in Delaware, combining virtual and in-person care provided by a team of physicians, nurse practitioners, registered nurses, and other providers. With in-person and virtual visits from the health care team, along with mobile imaging and lab services, delivery services for meals and nutrition, and pharmacy medication and management, our patients receive 24/7 hospital-level care in the comfort of their home. Virtual technology and

[1] ChristianaCare Brings Hospital Care to You, in the Comfort of Your Home - ChristianaCare News

home health equipment ensure round-the-clock monitoring and care that mirror a traditional acute hospital setting.

Since launching our program, ChristianaCare has found that AHCaH delivers excellent clinical outcomes, including substantial reductions in adverse events and improved patient and family experience.[2] As we near our 1,000th patient, ChristianaCare believes that AHCaH is critical to the future of home-based care delivery for Medicare patients and beyond. We are grateful for the legislative support that ensured that this kind of care remained possible beyond the COVID-19 Public Health Emergency, including the bipartisan legislative champions of the *Hospital Inpatient Services Modernization Act*, led by Congressmen Brad Wenstrup, D.P.M. (R – OH) and Earl Blumenauer (D – OR) and Senators Tom Carper (D – DE) and Tim Scott (R – SC). By providing a two-year extension of the current AHCaH waiver through the end of 2024, Congress has sustained the existing momentum and investment in the program, as well as allowed for additional experience and data collection that can inform the longer-term model for these services in the Medicare and Medicaid program.

The AHCaH waiver program has been and continues to be a reliable and impactful model to deliver effective care, lead to high patient satisfaction, and demonstrate positive outcomes. To avoid any disruption in access to Medicare beneficiaries and reinforce the need for broader adoption of advanced care at home, ChristianaCare asks Congress to prioritize a long-term solution that highlights the importance of redesigning the health care system to one that is more convenient and efficient than ever before and ensures the best care, at the best time, in the best place for each person's needs.

ChristianaCare appreciates your consideration and welcomes the opportunity to serve as a resource as Congress weighs the future of the AHCaH waiver program. We look forward to working with the Committee to further improve care delivery on behalf of the patients and communities we serve. If you have any questions, please contact Geoff Heath, Director of Federal Government Affairs & Policy, at geoffrey.a.heath@christianacare.org or 302-428-6590.

[2] Kimberly's Story: Hospital Care at Home - ChristianaCare News

Statement for the Hearing Record from the American Association of Cardiovascular and Pulmonary Rehabilitation Before the House Ways and Means Committee Hearing on "Enhancing Access to Care at Home in Rural and Underserved Communities" Tuesday, March 12, 2024

Chairman Smith, Ranking Member Neal, and members of the Ways and Means Committee, thank you for the opportunity to provide comments on the opportunities and challenges to enhancing access to care in patients' homes and modernizing care in rural and underserved communities.

The American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR) is a multidisciplinary professional association comprised of health care professionals who serve in the fields of cardiac rehabilitation (CR), intensive cardiac rehabilitation (ICR), and pulmonary rehabilitation (PR). Members include cardiovascular and pulmonary physicians, nurses, exercise physiologists, physical therapists, behavioral scientists, respiratory therapists, dietitians, and nutritionists. Founded in 1985, AACVPR is dedicated to our mission of reducing morbidity, mortality, and disability from cardiovascular and pulmonary disease through education, prevention, rehabilitation, research, and disease management.

This hearing is an important recognition of the potential for care at home to improve the overall health of our patients, reduce hospital admissions, and decrease mortality. We urge Congress and members of this committee to **advance the bipartisan *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* (H.R. 1406/S. 3021).** This important legislation will allow Medicare beneficiaries to receive CR/ICR/PR services virtually in their homes through the use of real-time, audio-visual communications technology. This hybrid delivery of hospital-based CR/ICR/PR services was effective during the pandemic and allowed patients to continue to access these beneficial treatments. Unfortunately, patients lost virtual delivery of these services in the hospital setting when the public health emergency (PHE) expired on May 11, 2023. Although Congress, through passage of the *Consolidated Appropriations Act, 2023*, appropriately ensured that patients maintain access to virtual "telehealth" CR/ICR/PR services through December 31, 2024, this telehealth extension only applies to CR/ICR/PR services provided in physician offices, which represents less than five percent of CR/ICR/PR programs. It is vital that Congress act to maintain this life-saving access to virtual CR/ICR/PR services beyond the COVID-19 pandemic for the >95% of Medicare beneficiaries who access these services in the hospital setting.

Importance of Patient Access to Cardiac and Pulmonary Rehabilitation in the Home

Heart disease continues to be the leading cause of death for Medicare beneficiaries. According to the Centers for Medicare and Medicaid Services (CMS), 42% of Medicare beneficiaries aged 65 years and over have at least one heart condition. The Million Hearts Initiative[1] partners federal agencies and organizations such as AACVPR with the goal of raising national CR participation rates to 70% of eligible patients. Currently, less than 25% of Medicare beneficiaries who are eligible for CR attend even one session.

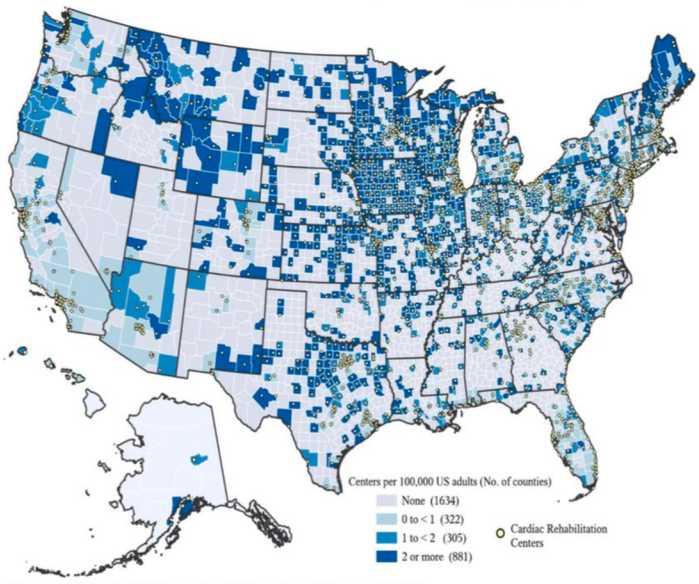
CR involves an individualized and personalized treatment plan, including evaluation and instruction on physical activity, nutrition, stress management, and other health related areas for patients who have

[1] https://millionhearts.hhs.gov/index.html

experienced a heart attack, angina, cardiac surgery (such as coronary bypass or valve surgery), coronary artery angioplasty or stents, heart failure, or heart transplantation. CR provides patients the opportunity to control heart disease symptoms such as chest pain or shortness of breath, lessen the physical and emotional effects of heart disease, and improve their stamina and strength.

Patients who participate in CR see reduced hospitalizations, decreased emergency department utilization, and lower mortality rates, and scientific studies have shown that people who complete a CR program can increase their life expectancy by up to five years. Nevertheless, a recently published article[2] found that "a total of 40 largely urban counties comprising 14% of the United States population age ≥65 years had disproportionately low CR access and were identified as CR deserts." It is estimated that there are a total of 2,351 CR centers in the U.S. – only one center per 100,000 adults.

Cardiac Rehabilitation Center Locations, 2018



In 2018, there were 2,351 cardiac rehabilitation centers in the United States for a rate of 1.0 centers per 100,000 adults.
Sources: American Community Survey 5-year estimate, adults 18+, 2014-2018; American Hospital Association Survey, Cardiac Rehabilitation Center locations, 2018.

Approximately 16.5% of Medicare beneficiaries have chronic obstructive pulmonary disease (COPD). The common symptoms of chronic lung disease include shortness of breath, fatigue, reduced muscle function, strength and ability to exercise, depression, and anxiety. PR is the standard of care for patients with chronic lung disease and its related symptoms. PR is a comprehensive intervention based on thorough

[2] J Am Coll Cardiol. 2023 Mar 21;81(11):1049-1060.doi: 10.1016/j.jacc.2023.01.016

patient assessment followed by patient-tailored therapies that include, but are not limited to, exercise training, education, and self-management intervention aiming at behavior change, designed to improve the physical and psychological condition of people with chronic respiratory disease and to promote the long-term adherence to health-enhancing behaviors.

PR is well established to be an effective therapeutic strategy to improve exercise tolerance, quality of life, breathlessness, and mood. Recent research has shown that Medicare patients who underwent PR within three months following hospitalization for COPD exacerbation had a 37% better survival rate at one year compared to those not attending PR.[3] Despite the evidence supporting the important role PR plays in reducing hospitalization and improving survival, a published study found that two-fifths of Medicare beneficiaries with COPD in a national sample, and eight in nine of those in rural areas, have poor access to PR[4].

Success of COVID-Era Flexibilities and Current Impediments of Access to Virtual CR/ICR/PR Services

During the pandemic, hospitals were allowed to provide some outpatient services through virtual means (real-time, audio-visual communications technology) to Medicare beneficiaries in the home. Hospital-based CR/ICR/PR programs were included in these PHE waivers which proved to be very beneficial since some centers shut down and staff re-deployed due to the pandemic. Beneficiaries living in rural areas or areas without a brick-and-mortar CR/ICR/PR program demonstrated comparable benefits to those patients who participated in center-based CR/ICR/PR programs. Virtual access also benefited patients facing other barriers to consistent participation in their treatment plan, such as those without transportation or the financial means to regularly travel to an in-person CR/ICR/PR center.

When the PHE expired on May 11, 2023, virtual delivery of these services in the hospital setting also ceased to be an option. Congress, through passage of the *Consolidated Appropriations Act, 2023*, appropriately ensured that patients maintain access to virtual "telehealth" cardiac and pulmonary rehabilitation services through December 31, 2024. **However, the current telehealth extension only applies to CR/ICR/PR services provided in physician offices, which represents less than 5% of programs. CMS does not have the authority to allow virtual delivery of hospital outpatient services, including CR/ICR/PR, beyond the expiration of the PHE, necessitating legislative action by Congress.**

Sustainable Cardiopulmonary Rehabilitation Services in the Home Act (H.R. 1406/S. 3021)

The *Sustainable Cardiopulmonary Rehabilitation Services in the Home Act* was introduced in the House of Representatives by Reps. John Joyce, MD (R-PA) and Scott Peters (D-CA), and in the Senate by Sens. Kyrsten Sinema (I-AZ), Marsha Blackburn (R-TN), and Amy Klobuchar (D-MN). The bill would improve patient access to CR/ICR/PR services by permanently allowing Medicare patients to receive these services via virtual telecommunications technology (real-time, audio-visual) in the beneficiary's home (which would serve as the originating site), wherever the home is located throughout the country, including when those services are furnished by hospitals as distant site providers. Additionally, virtual direct supervision by physicians, physician assistants, nurse practitioners, or clinical nurse specialists would be allowed through real-time, audio-visual communications technology.

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[3] Lindenauer PK, Stefan MS, Pekow PS, et al. Association between initiation of pulmonary rehabilitation after hospitalization for COPD and 1-year survival among Medicare beneficiaries. JAMA. 2020 May 12;323(18):1813-1823. doi: 10.1001/jama.2020.4437

[4] Malla G, Bodduluri S, Sthanam V, Sharma G, Bhatt SP. Access to pulmonary rehabilitation among Medicare beneficiaries with chronic obstructive pulmonary disease. Ann Am Thorac Soc2023;20:516–522

In addition to AACVPR, the bill is supported by the American Association for Respiratory Care, American College of Chest Physicians, American College of Cardiology, American Thoracic Society, and the COPD Foundation. Thirty-five patient and provider groups, health systems, and industry organizations have sent a letter[5] in support of the legislation.

Rehabilitation care only works when done consistently, and patients who do not engage in CR/ICR/PR for extended periods of time are likely to stop rehabilitation all together. AACVPR is committed to ensuring access to CR/ICR/PR services for the patients we serve, including through home-based rehabilitation, and looks forward to working with the committee to advance this important patient access legislation.

[5] https://heartrehabcare.org/s/Virtual-CR-PR-Sign-On-Letter-For-Distribution-2024-01.pdf

AMERICAN ACADEMY OF FAMILY PHYSICIANS

March 12, 2024

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
U.S. House of Representatives
300 Cannon House Office Building
Washington, D.C. 20515

Dear Chairman Smith and Ranking Member Neal:

On behalf of the American Academy of Family Physicians (AAFP), representing more than 130,000 family physicians and medical students across the country, I write to thank the Committee for its focus on enhancing access to care in patients' homes and modernizing care in rural and underserved communities with today's hearing.

The AAFP has long advocated to improve access to high-quality care in rural communities. Seventeen percent of our members live and work in rural areas, the highest percentage of any medical specialty, and they are often the only physician embedded in the community. Family physicians are uniquely trained to provide a broad scope of health care services to patients across the lifespan. This enables them to tailor their practice location and individual scope of practice to the needs of their communities, including delivering care in a patient's residence.

Family physicians have always provided home care or "house calls." Home-based primary care allows family physicians to spend more time with their patients and deliver person-centered care in the setting most comfortable to them. Since home health care often requires continuing and comprehensive patient care in a family context, family physicians are particularly well-qualified and trained to provide home health care. Thus, the patient's family physician should be directly involved in the initial decision to provide home health care services plus the subsequent planning, provision and management of those services. Additionally, adequate compensation for family physicians providing and managing home health care services will help ensure on-going home health care access and availability.

Without access to home-based primary care, many patients have no option but to seek necessary care in an emergency department.[1] It is with these considerations in mind that we offer the following policy recommendations to improve access to home-based primary care in rural and underserved communities.

Payment Reform

Home-based primary care has the potential to ensure coordinated care, reduce reliance on more expensive settings such as emergency departments, and yield better patient outcomes through improved access to care, treatment adherence, and management of chronic conditions. However, home-based primary care also requires significant investments and revenue streams that allow said investments to be made. Patient-centered home-based primary care is enabled through technology,

such as electronic medical records that can be accessed anywhere, lab tests that can be performed in the home, and portable equipment such as x-rays and ultrasounds.

Yet fee-for-service (FFS) payment, which remains the dominant system for physician payment, takes a piecemeal approach to financing primary care, including home-based primary care, undermines and undervalues the whole-person approach integral to primary care. It hinders the ability for rural family physicians to provide care in a way that is organic and responsive to their community. **Shifting away from FFS and investing in the transition to value-based care will allow rural primary care to be delivered in the ways that are most meaningful for the community's needs, including at home.**

The AAFP has long advocated for APMs that increase the investment in primary care using prospectively paid, population-based payments. **Participating in APMs that offer predictable, prospective revenue streams using population-based payments enables practices to invest in the infrastructure and care teams needed to deliver high quality, comprehensive primary care that meets the needs of their patients, such as in their home – without the administrative complexity of FFS**. Given these and other benefits, there is mounting multi-stakeholder, cross-industry support for a primary care payment system that rewards value and holds promise for improving health, addressing disparities, and slowing the overall growth of health care costs. **Federal policymakers should increase participation opportunities in primary care models that align with the AAFP's guiding principles for value-based payment (VBP) and meet practices where they are, allowing them to gain a foothold in VBP.**

While fee-for-service is not the future of primary care, though, it is the present. Federal policymakers must ensure the current FFS system appropriately and sustainably compensates physicians to make more meaningful progress toward the future – one that rewards quality of care over volume of services. Primary care practices need an environment that allows them to thrive, but inadequate payment rates threaten their long-term viability. This is especially true in rural and medically underserved communities, where simply participating in Medicare and Medicaid is economically detrimental to independent practices. However, backing out would mean that these patients – who make up the greatest portion of a panel, especially of home-bound patients – are unlikely to access care elsewhere.

Rural communities are disproportionately impacted by insufficient FFS payments. They have smaller patient volumes that are older and more likely to have chronic illnesses, multiple health concerns, and be low-income. Rural areas see higher rates of uninsured and Medicare and Medicaid patients, meaning significantly lower payment rates and more expensive, uncompensated care. Patients requiring home-based care, in particular, tend to be more medically complex and thus "costlier" in terms of services required.

Therefore, **the Academy strongly continues to urge the Committee to prioritize legislative solutions that would address unsustainable FFS payment rates for physicians and promote community- and more specifically home-based primary care**, including in rural and underserved communities.

The Academy has heard from some family physicians that their practices have had to stop accepting new Medicare beneficiaries altogether due to financial constraints, leaving them unable to address the needs of the entire community that they're trained to serve. While we appreciate recently implemented policy changes intended to further invest in primary care, **budget neutrality requirements undermine these steps in the right direction by requiring Medicare to offset increased investment with across-the-board payment cuts to all services.** This dynamic has

only exacerbated our underinvestment in primary care within FFS: primary care's voice is drowned out as organized medicine competes for arbitrarily limited resources without adequate focus on the services that would drive population health improvements and health equity while reducing costs.

Further, **the AAFP urges the Committee to pass legislation that would provide an annual update to the MPFS based on the Medicare Economic Index (MEI)**. This annual update is an important first step in reforming Medicare payment to help practices keep their doors open, resist consolidation, and ensure continued access to care for beneficiaries across settings. Stable, adequate FFS payments are also a vital component in the transition to value-based care, particularly for practices serving rural, low-income, and other underserved communities. Success in alternative payment models happens through practice transformation and quality improvement, which requires upfront resources and stable, prospective revenue streams to hire care managers and behavioral health professionals and make significant investment in practice capabilities including technology, people, and new workflows.

Innovative Care Delivery and Payment Models

Independence at Home demonstration: The Academy has supported the Independence at Home (IAH) demonstration at the Center for Medicare and Medicaid Innovation (CMMI), which provided chronically ill patients with a complete range of primary care services in the home setting. The demonstration ended on December 31, 2023 after receiving a three-year extension in the Consolidation Appropriations Act of 2021.

The demonstration tested whether home-based care reduced the need for hospitalization, improved patient and caregiver satisfaction, and lead to better health and lower costs to Medicare. Practices that succeeded in meeting quality measures while generating Medicare savings had an opportunity to receive incentive payments after meeting a minimum savings requirement.

IAH was based on decades of data showing that home-base primary care is an effective way to deliver care for seriously ill patients and to produce savings. Research shows that the demonstration program produced high quality care for seniors with chronic diseases and met their complex needs. In the most recent evaluation report for 2021 – the second year of the COVID-19 pandemic – **IAH was shown to reduce inpatient spending by 9.6 percent and the probability of a patient dying by any cause by 16.3 percent.**[2] The expenditures for participants' applicable beneficiaries were approximately 21.3 percent or $32 million below their spending targets.[3] Given these findings, the AAFP encourages federal policymakers to continue to invest in and make available VBP opportunities that support primary care physicians' ability to deliver high quality care through the settings or modalities that most appropriately meet their patients' needs, including in their home.

Direct primary care: A growing number of family physicians are choosing to practice direct primary care (DPC), which gives family physicians a meaningful alternative to fee-for-service billing. DPC arrangements typically involve charging patients a monthly, quarterly or annual fee (i.e., a retainer) that covers all or most primary care services, including clinical, laboratory and consultative services as well as care coordination and comprehensive care management. Monthly membership fees typically range from $50 to $100 per adult. Many DPC practices offer home-based services for patients either as part of or in addition to their flat fee.

The AAFP supports direct primary care (DPC) and sees it as a model of care that provides a pathway to continuous, comprehensive and coordinated primary care for patients. For family physicians, this revenue model can stabilize practice finances, allowing the physician and office staff to focus on the needs of the patient and improving their health outcomes rather than coding and billing. Given that

health care costs have been skyrocketing for patients and many report being unable to afford necessary health care, it is not surprising that patient demand for DPC practices is growing. Additionally, employers and labor unions are driving growth in the model through benefits being offered to their employees and members. For example, two-thirds of family physicians surveyed in AAFP's 2022 DPC Study reported they participate in employer-based contracts.[4]

However, there are remaining barriers that prevent some patients from realizing the full potential of the DPC model. One of those barriers is the prohibition on the permissible use of health savings accounts (HSAs) funds to pay for participation in a DPC practice. Under existing interpretation of the Internal Revenue Code, patients with HSAs are prohibited from engaging in DPC arrangements with a family physician or other primary care clinician. The *Primary Care Enhancement Act* (H.R. 3029) would remove this current legal barrier and ensure that patients with HSAs can use those funds to pay for DPC arrangements. The Academy applauds the Committee for favorably reporting out this policy in September as part of a larger package, and **we continue to urge Congress to take further action to ensure that patients can more easily and affordably access primary care services suited to their unique needs, including in their home.**

Telehealth

Telehealth was undoubtedly a lifeline for many patients seeking care from their homes during the COVID-19 pandemic, and it has significantly shifted the accessibility of and interest in care received from their homes for more patients since. Telehealth, when implemented thoughtfully, can improve the quality and comprehensiveness of patient care, and expand access to care for rural and under-resourced communities and vulnerable populations. **The AAFP strongly believes that permanent telehealth coverage and payment policies should:**

- **Ensure coverage and access to audio/video and audio-only telehealth services for all Medicare beneficiaries, regardless of their physical or geographic location;**
- **Include guardrails to ensure care continuity and quality by encouraging the use of telehealth with a patient's usual primary care physician or another trusted care relationship; and**
- **Enable patients, in consultation with their trusted primary care physician, to determine the most appropriate modality of care for each encounter.**

Telehealth should also enable higher-quality, more personalized care by making it more convenient and accessible for patients. Expanding telehealth services in isolation, without regard for a previous patient-physician relationship, medical history, or the eventual need for a follow-up hands-on physical examination, can undermine the central value offered by a usual source of primary care, impede a continuous and comprehensive patient-physician relationship, increase care fragmentation, and lead to the patient receiving suboptimal care.

Telehealth is essential for many rural residents, who may encounter significant barriers such as distance, financial, insurance coverage, or lack of transportation to easily access in-person care. However, **existing barriers continue to hinder the ability for individuals in rural communities to access quality telehealth services, as well**. The lack of modern broadband infrastructure has proven to be a primary barrier to equitable telehealth and digital health access for rural Americans, who are ten times more likely to lack broadband access than their urban counterparts, leading to fewer audio/video visits.[5,6,7]

In many instances, **family physicians have reported that some of their patients, particularly seniors, are most comfortable with or can only access audio-only telehealth visits.** One recent

study of FQHCs found that, by mid-2022, one in five primary care visits and two in five behavioral health visits were audio-only, and audio-only visits were still more common than video visits.[8] Therefore, permanent telehealth policies must include coverage of and proper payment for audio-only telehealth services across programs.

Adequate payment for audio-only telehealth services helps facilitate equal access to care for rural and underserved communities and enables patients and physicians to select the most appropriate modality of care for each visit. Physicians should be appropriately compensated for the level of work required for an encounter, regardless of the modality or location. The cognitive work does not differ between in-person and telemedicine visits. Policies should be geared at providing more tools, not less, to primary care physicians so they can provide the familiar and quality care their patients seek. Payment should reflect the equal level of physician work across modalities while also accounting for the unique costs associated with integrating telehealth into physician practices.

The AAFP strongly urges Congress to pass the *Protecting Rural Health Access Act* (S. 1636 / H.R. 3440), which would ensure rural and underserved community physicians can permanently offer telehealth services, including audio-only telehealth services, and provide payment parity for these services. The available data clearly indicates that coverage of and fair payment for audio-only services is essential to facilitating equitable access to care after public health emergency-related telehealth flexibilities expire.

This legislation would also permanently remove the current section 1834(m) geographic and originating site restrictions to ensure that all Medicare beneficiaries can access telehealth services at home, which the AAFP has advocated to Congress in favor of previously. The COVID-19 pandemic demonstrated that enabling physicians to virtually care for their patients at home can not only reduce patients' and clinicians' risk of exposure and infection but also increase access and convenience for patients, particularly those who may be homebound or lack transportation. Telehealth visits can also enable physicians to get to know their patients in their home and observe things they normally cannot during an in-office visit, which can contribute to more personalized treatment plans and better referral to community-based services.

Finally, the *Protecting Rural Telehealth Access Act* would permanently allow RHCs and FQHCs to serve as distant site for telehealth services. As noted above, FQHCs and RHCs are essential sources of primary care for patients in underserved communities, including low-income individuals and those living in rural areas. During the pandemic, FQHCs and RHCs made significant investments to integrate telehealth into their practices and ensure equitable access to telehealth services for their patient populations. Passing this bill would ensure these facilities can continue to provide telehealth services, improve equitable access to health care for historically underserved patients, and preserve care continuity with their primary care physicians.

The AAFP has also continuously advocated for and supported legislative proposals to permanently remove CMS' in-person requirement for telemental and behavioral health visits. Evidence has shown that telehealth is an effective modality for providing mental and behavioral health services.[9,10] Meanwhile, family physicians report that persistent behavioral health workforce shortages create significant barriers to care for their patients, which are even more pronounced in rural areas. Arbitrarily requiring an in-person visit prior to coverage of telemental health services will unnecessarily restrict access to behavioral health care. Removing the in-person requirement would improve equitable access to care for low-income patients and those in rural communities. We note that our position on in-person visit requirements is unique to telemental health services.

As the current payment landscape still largely relies on fee-for-service, it is vital to promote telehealth policies that provide adequate payment to protect access and the patient-physician relationship. However, **the best long-term solution is a payment system that moves away from the transactional and focuses on payment that better supports whole-person primary care.** Reliable, prospective payment that that is agnostic of care modality or encounter fosters innovations that allow practices to meet the diverse needs of their patient populations.

Thank you for your continued attention on the need to enhance and modernize access to care in rural and underserved communities, including home-based primary care. The AAFP looks forward to working with you on the policy recommendations outlined above to do just that. Should you have any additional questions, please contact Natalie Williams, Senior Manager of Legislative Affairs at nwilliams2@aafp.org.

Sincerely,

Tochi Iroku-Malize, MD, MPH, MBA, FAAFP
American Academy of Family Physicians, Board Chair

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Statement for the Record Submitted by the
Association of American Medical Colleges to the
House of Representatives Committee on Ways and Means:
"Enhancing Access to Care at Home in Rural and
Underserved Communities"
Submitted March 12, 2024

The Association of American Medical Colleges (AAMC) appreciates the opportunity to submit this statement for the record for the House Committee on Ways and Means March 12 hearing, "Enhancing Access to Care at Home in Rural and Underserved Communities." The AAMC applauds the Committee for focusing on the tremendous potential of care at home to improve the lives of patients in our nation's rural and underserved communities.

AAMC-member teaching hospitals and health systems, medical schools, and faculty physicians have long been at the forefront of innovative care delivery. The COVID-19 public health emergency (PHE), though incredibly challenging for our members, proved to be an opportunity to enhance delivery in new care settings – especially the home. Our members rapidly expanded their existing telehealth capabilities, ensuring that patients could still access their providers despite restrictions on their ability to see their physicians in person. Many of our members also invested in Acute Hospital Care at Home (AHCaH) programs, which proved to not only help alleviate pressing capacity issues but also accelerate the development and implementation of more home-based care options. The AAMC believes that telehealth and AHCaH are integral to enhancing access to care in rural and underserved communities, and we urge you to refer to our Oct. 4, 2023 response to the Committee's request for information on "Improving Access to Health Care in Rural and Underserved Areas."

The AAMC is a nonprofit association dedicated to improving the health of people everywhere through medical education, health care, medical research, and community collaborations. Its members are all 158 U.S. medical schools accredited by the Liaison Committee on Medical Education; 13 accredited Canadian medical schools; approximately 400 academic health systems and teaching hospitals, including Department of Veterans Affairs medical centers; and more than 70 academic societies. Through these institutions and organizations, the AAMC leads and serves America's medical schools, academic health systems and teaching hospitals, and the millions of individuals across academic medicine, including more than 193,000 full-time faculty members, 96,000 medical students, 153,000 resident physicians, and 60,000 graduate students and postdoctoral researchers in the biomedical sciences. Following a 2022 merger, the Alliance of Academic Health Centers and the Alliance of Academic Health Centers International broadened participation in the AAMC by U.S. and international academic health centers.

The Acute Hospital Care at Home (AHCaH) Program and Academic Medicine
The Centers for Medicare and Medicaid Services (CMS) launched the Hospital Without Walls program in March 2020 to allow hospitals to provide services beyond their existing walls to help

address the need to expand care capacity and to develop sites dedicated to COVID-19 treatment. AHCaH was implemented as an expansion of this initiative that provides eligible hospitals the regulatory flexibility to treat certain patients, who would otherwise be admitted to the hospital, in their homes and for those hospitals to receive Medicare payment under the Inpatient Prospective Payment System for those patients.

The AHCaH program launched with six health care systems that had experience with providing acute hospital care in a patient's home. To date, 315 hospitals across 131 health systems located in 37 states – including many teaching health systems and hospitals – have received waivers from CMS to participate in the program.[1] The increase in hospital participation underscores the critical need for continued flexibility to meet the health care needs of certain patients without having to admit them into the inpatient setting. Though the COVID-19 PHE is no longer in effect, teaching hospitals and health systems continue to expand their existing AHCaH programs, and additional hospitals are applying for the waiver now. Teaching hospitals routinely experience capacity challenges by virtue of their roles as safety net providers and AHCaH programs are a valuable resource to both alleviate capacity issues and provide patients access to care in the comfort of their home.

Advancements in Patient Care, Safety, and Outcomes

AAMC member teaching health systems and hospitals report positive outcomes and high patient satisfaction from their AHCaH patients and families. Analysis from studies on AHCaH programs reveal that the program can also lower the cost of care as well as reduce the number of hospital readmissions.[2] There exist also scenarios where patients with both uncomplicated and complex conditions alike benefit greatly from being in their homes. As a result of the numerous successes and tremendous potential, our members have made robust investments in their AHCaH programs with some considering their programs as a long-term solution to ongoing capacity concerns.

Participating hospitals are required to regularly report data that include key measures such as patient volume, unanticipated mortality, escalation rate, details about the institution's safety committee, and the patient list. CMS has established parameters around the program to emphasize patient safety. A recent analysis of data on the program has indicated that patients treated under AHCaH had a low morality rate and minimal complications.[3]

Extending AHCAH

AAMC teaching health systems and hospitals view AHCaH as a way to transform care to meet patients' needs. However, our members and their patients face uncertainty regarding the future of the program due to its pending expiration. For investments in AHCaH programs to continue and for more patients to be able to access this type of care, hospitals need certainty that the program

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[1] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources
[2] https://psnet.ahrq.gov/innovation/hospital-homesm-care-reduces-costs-readmissions-and-complications-and-enhances
[3] Adams D, Wolfe AJ, Warren J, et al. Initial Findings From an Acute Hospital Care at Home Waiver Initiative. *JAMA Health Forum.* 2023;4(11):e233667. doi:10.1001/jamahealthforum.2023.3667

will continue for a significant period of time. A longer extension of the program, and the certainty that it brings will spur additional innovations in the program.

Congress extended the AHCaH program until December 31, 2024 in the Consolidated Appropriations Act, 2023 (P.L. 117-328). The AAMC supported the extension efforts, and urges the Committee to consider legislation that would extend the program once more. It is crucial for teaching health systems and hospitals to have certainty in the continuity of this program, particularly as they continue to make investments to expand and improve their AHCaH programs. We urge you to work on the extension of this program well before the December 31 deadline and to eliminate the uncertainty hospitals and health systems will undoubtedly face if Congress fails to act in a timely fashion.

Conclusion

The AAMC applauds the Committee for highlighting the importance of home-based care, and we urge you to pass legislation to extend the COVID-19 telehealth waivers and the AHCaH program to improve access to care and so that patients everywhere can continue to benefit.

AARP
STATEMENT FOR THE RECORD
for the

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON WAYS AND MEANS
on

ENHANCING ACCESS TO CARE AT HOME AND IN RURAL AND UNDERSERVED COMMUNITIES

March 12, 2024
Washington, DC

AARP, which advocates for the more than 100 million Americans age 50 and older, appreciates the Committee's efforts to examine enhancing access to care at home in rural and underserved communities. According to AARP's 2021 Home and Community Preferences Survey, the vast majority of adults age 50-plus—nearly 80 percent—want to remain in their communities and homes as they age. As the delivery of care evolves, more individuals are receiving care in their homes, whether after discharge from a hospital, skilled nursing facility, or other institutional setting, through home health care or home care, even hospital care at home, as well as help with daily activities such as eating, bathing, and dressing or medical/nursing tasks. More and more, home is the new frontier of health care.

Often, a family caregiver is the first and closest point of contact in providing care. As the Committee and Congress consider access to care at home, it is essential to consider the implications for family caregivers and the support they need, given their role in the care system. Care at home, the role of family caregivers, and the support they need are inextricably linked. While there are many individuals who play an important role as a member of an individual's care team, this statement will focus more specifically on the important role of the family caregiver(s).

America's more than 48 million family caregivers are the backbone of the care system in this country, helping older adults, people with disabilities, and veterans live independently in their homes and communities – where they want to be. They comprise the largest number of health care workers. The physical, emotional, and financial challenges they face in their caregiving roles cannot be overstated, exemplified by a poll released by AARP last year on family caregivers.

Family caregivers provide $600 billion annually in unpaid labor to their loved ones. This includes assisting with daily activities such as eating, bathing, dressing, meal preparation, finding and coordinating care, managing medications, transportation to medical and other appointments, performing complex medical/nursing tasks, supporting their loved one through care transitions such as from hospital to home, managing finances, and so much more. Over half (56 percent) of family caregivers advocate with care providers, community services, or government agencies on behalf of their loved one. Among those coordinating care, 30 percent find it difficult to do so. The assistance caregivers provide saves taxpayers billions of dollars, such as by helping to delay or prevent more costly nursing home care and unnecessary hospital stays. Without them, America's health and long-term care systems would collapse. However, too often, family caregivers do not get the support, including education and training, that they need to take care of the person they are assisting. Caregivers tell us, for example, that they often feel unprepared for their growing health care responsibilities, which include managing medications, helping with wound care, running specialized medical equipment, and administering injections. They are seldom recognized as a part of our health care system and health care workforce. Six in ten family caregivers are also balancing outside employment with caregiving responsibilities.

The care that families and friends provide is invaluable for those receiving it, and is a precious resource for the communities, cities, and states wrestling with the realities of an aging population and the declining ratio of potential family caregivers in the smaller subsequent generations. In terms of providing care in a rural area, typical caregivers of someone who lives in a rural area

have lower education and household income than caregivers of those living in a suburban or urban area. Caregivers of someone living in a rural area typically do not live in a rural area themselves. Caregivers of rural-living recipients more often report high levels of financial strain and have experienced a greater number of financial impacts due to caregiving. Family caregivers on average spend over $7,200 annually in out-of-pocket caregiving expenses. Caregivers of rural-living recipients more often have difficulty taking care of their own health and less often report having health insurance.

AARP urges Congress to provide caregivers needed support, including: provide financial relief to family caregivers through a family caregiver tax credit under the Credit for Caring Act (H.R. 7165) and pre-tax health expense payment accounts under the Lowering Costs for Caregivers Act (H.R. 7222); help save family caregivers time by connecting them to Medicare as in the Connecting Caregivers to Medicare Act (H.R. 7274) and reducing red tape; and provide them with other assistance such as respite care to give them a temporary break, education, training, help finding the resources they need, and more, including in Hospital at Home programs, as their loved one moves from one place of care to another, and in Medicare more broadly. The bills noted above are commonsense bipartisan solutions that would help save family caregivers time and money. It is important to make providing care – and finding paid care – easier for family caregivers; alleviate the economic, financial, and other challenges directly associated with caregiving responsibilities; and increase and ensure access to support for all family caregivers.

Hospital at Home Programs

One of the ways that care at home has grown over the last few years is through Hospital at Home (HaH) programs. While in existence for several decades, the model rapidly expanded during the COVID-19 pandemic once the Centers for Medicare & Medicaid Services' (CMS) created a temporary waiver, the Acute Hospital Care at Home (AHCaH) Waiver, that allowed hospitals to offer certain acute-level care in the home with the same inpatient designation as in a physical hospital. An ultimate driver of the growth was the Medicare reimbursement that offered this in-home care at the same rate given for in-hospital care. Other reasons include limited staffing, bed shortages, and consumer hesitation of hospitals. The AHCaH waiver serves eligible Medicare Fee-for-Service (FFS) and nonmanaged care Medicaid beneficiaries. Congress extended the AHCaH waiver through 2024. CMS is conducting a study and report on the waiver, required by Congress by September 30, 2024.

Existing research studies focus on outcomes such as patient improvement and safety. There is a dearth of findings that reflect the impact of HaH programs on the family caregiver. The limited findings that do exist laud support for the family caregiver in examples such as savings on daily parking rates, access to providers without having to juggle work or other obligations to meet in-hospital schedule demands, and reduced strain with having to go back and forth to the hospital. However, there are minimal insights into the full experience of the family member or friend. We note that as the Medicare Payment Advisory Commission (MedPAC) is examining the AHCaH waiver, they have also been discussing and considering the impact on and experience of family caregivers. Key considerations (some highlights below) that should be addressed when a patient with a family caregiver is being offered HaH as an option of care include:

- Recognize and Support the Family Caregiver – In homes where a family caregiver is present or required, it is important to understand the critical role they serve in making this a successful "stay." Each program should consider and understand the needs and preferences of each family unit, including the family caregiver, in relation to what they are being asked to do. Recognizing these individual needs is done through intentional engagement with family caregivers and the person receiving the care. Clear communication between the provider, patient, and family caregiver will lead to a mutual understanding of the full range of needs as well as the ability and willingness of both the patient and family member or friend to make this a viable option for care both during the "stay" and as the person transitions and is discharged. Services and supports should be available and provided to meet needs of both the patient and family caregiver.
- Be Clear and Understandable to the Patient and Family Caregiver – It is important that when an HaH program is offered as an option, both the patient and the family caregiver should have a clear understanding of exactly what the program involves and expectations, particularly of the family member or friend as it relates to the patient's care while in the program. For example, telling a caregiver they should be present for delivery of medical equipment or to receive the provider should include the fact that there are windows within which the service may be rendered, thereby respecting the caregivers time and other potential commitments. Will the family caregiver be responsible for helping with toileting, giving medications, etc.? If so, are there supports for that person?
- Ensuring Choice, Access, and Equity – When the HaH program is offered, it should be made clear to both the family caregivers and the patient that this is a voluntary option and programs should request that the caregiver assent/agree to guarantee voluntary participation. Criteria in place to determine who qualifies for these programs should be inclusive, ensuring that potential existing barriers that could lead to disparities in equitable access be eliminated. If the recipients of these in-home services are not representative of the community which the hospital services, it is important to understand why and address any equity issues.
- Allow for Appropriate Levels of Research and Learning – As mentioned, there is currently only limited information on the experiences of family caregivers as care shifts into the home through formal programs such as HaH. Nearly 60 percent of family caregivers provide complex medical/nursing care in the home generally. This care can lead to stress, worry about making a mistake, and feelings of isolation. The more that is understood about caregiver needs, the better communication and support can be offered. It is important to understand the team who is in the home and providing assistance and technical tasks (including medical/nursing tasks) and what leads to positive health outcomes, as well as what happens when there is no family caregiver.

Congress should address these family caregiver considerations as they consider potential extension of the AHCaH waiver. As care continues to move into the home, it is vital to address the impacts on and recognize and support family caregivers and the critical role they play in such care.

Conclusion

Thank you for the opportunity to provide AARP's perspective on enhancing access to care at home in rural and underserved areas. An important part of doing so is ensuring support for family caregivers who themselves are often providing and/or paying for care for their loved ones. We look forward to working with you to address this important issue and ensure continued support for our nation's family caregivers.

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Statement

of the

American Hospital Association

for the

Committee on Ways and Means

U.S. House of Representatives

"Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 health care leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on how telehealth flexibilities, the hospital-at-home (H@H) program and home health agencies have expanded access to care for patients in their homes and the need for these programs to continue.

TELEHEALTH COVID-19 FLEXIBILITIES HAVE IMPROVED ACCESS TO CARE

At the outset of the COVID-19 pandemic, the federal government moved quickly to ensure hospitals and health systems were able to respond efficiently and effectively to a wave of unprecedented need. The Centers for Medicare & Medicaid Services (CMS) waived certain regulatory requirements and Congress provided significant legislative support to ensure hospitals and health systems could manage the numerous challenges facing them, including by increased virtual care options. These swift actions provided hospitals and health systems with critical flexibilities to care for patients during what has been a prolonged and unpredictable pandemic.

We greatly appreciate the committee's focus on this critical issue and urge Congress to make these key telehealth flexibilities permanent before they expire on Dec. 31, 2024:

- Removing geographic restrictions and expanding originating sites to include any site at which the patient is located, including the patient's home.
- Expanding eligible practitioners to furnish telehealth services to include occupational therapists, physical therapists, speech-language pathologists and audiologists.
- Extending the ability for federally qualified health centers (FQHCs) and rural health clinics (RHCs) to furnish telehealth services.
- Delaying the six-month in-person requirement for mental health services furnished through telehealth, including the in-person requirements for FQHCs and RHCs.
- Extending coverage and payment for audio-only telehealth services.
- Extending the ability to use telehealth services to meet the face-to-face recertification requirement for hospice care.

CONNECT for Health Act

The AHA supports the CONNECT for Health Act of 2023 (H.R. 4189/S. 2016), comprehensive legislation which addresses many of these waivers. Patients across geographies and settings, including both rural and urban areas, have benefited from increased access and improved convenience provided by telehealth services. We support permanently removing geographic restrictions that currently limit where patients can access telehealth services. Removing these unnecessary barriers would ensure all Medicare beneficiaries can access services regardless of where they and their providers are physically located.

Behavioral health is one specialty area that has seen sustained growth in telehealth utilization. Geographically dispersed patients have benefited from increased access to behavioral health services provided through telehealth, especially in areas that may have provider shortages and in-person visits are not possible. As a result, we support the proposed removal of the requirements that a patient must receive an in-person evaluation six months before they can initiate behavioral telehealth treatment and must have an in-person visit annually thereafter.

Additionally, the AHA supports allowing rural health clinics and federally qualified health centers to serve as distant sites, so that these facilities may use the providers at their own sites to offer care to patients, ensuring patients remain connected to their primary providers. The AHA also supports allowing critical access hospitals (CAHs) the same ability to offer and bill for telehealth services and would encourage consideration of adding language to include CAHs as eligible distant sites.

We also appreciate the ability to waive restrictions on the use of telehealth during national and public health emergencies (PHE) and support improving Medicare's process for coverage of telehealth services given the positive impact of improving patient's access to care.

Continuing Payment and Coverage for Audio-only Telehealth Services

We urge the committee to consider support for audio-only telehealth services payment and coverage. Virtual care represents a spectrum of ways that telecommunications technologies can be used in care delivery, from synchronous real-time video visits to audio-only phone visits to remote monitoring of patient vitals. Prior to the pandemic, most payers, including Medicare, required that telehealth be performed using real-time audio-visual technologies. However, COVID-19 PHE waivers allowing coverage of audio-only services provided a needed access point for patients who had bandwidth constraints, lacked data plans or devices to support video-based visits, or who otherwise were not able to participate in audio-visual encounters. Continued coverage and reimbursement for audio-only services will ensure that patients without access to technology are still able to access care where clinically appropriate. Therefore, we would encourage the explicit addition of Medicare coverage and payment for audio-only services in statute.

Removing Unnecessary Barriers to Licensure

Prior to the pandemic, many states required that out-of-state providers delivering telehealth have a license in the state where the patient was located. However, COVID-19 PHE waivers allowing licensure flexibilities including abbreviated applications and reciprocity arrangements enabled provision of care across state lines more easily. Reducing barriers to licensure can help maximize limited provider capacity, particularly in areas where there are shortages. The AHA supports efforts to ensure that licensure processes are streamlined for providers employed by hospitals and health systems operating across state lines and encourages additional research be done on the feasibility, infrastructure, cost and secondary effects of licensure reform options.[1] Hospitals, health systems, providers and patients have seen the benefits and potential for telehealth to increase access and transform care delivery. We appreciate your leadership on this important issue and look forward to working together to ensure telehealth permanency.

HOSPITAL AT HOME PROGRAMS HAVE TRANSFORMED HEALTH CARE DELIVERY

The hospital-at-home model — where patients receive acute level care in their homes, rather than in a hospital — has emerged as an innovative and promising approach to provide high quality care to patients in the comfort of their home. To allow providers to continue to take steps to transform care delivery in a way that improves patient experience, the AHA strongly supports the continuation of this program.

To allow hospitals and health systems the ability to respond to the COVID-19 pandemic effectively and efficiently, CMS provided a number of waivers and flexibilities that eased

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[1] Telemedicine and Medical Licensure — Potential Paths for Reform | NEJM

several Medicare restrictions and requirements to allow hospitals and health systems to effectively and efficiently respond to the COVID-19 pandemic.

Hospitals continue to see H@H programs as a safe and innovative way to care for patients in the comfort of their homes. A growing body of research shows that H@H is an effective strategy that improves all three components of the value equation — improve outcomes, enhance the patient experience and reduce cost. A meta-analysis of 61 studies found that patients that have received hospital-at-home care have a 20% reduction in mortality while another randomized control trial found that acutely ill patients admitted to H@H through the ED were three times less likely to be admitted to the hospital within 30 days than usual inpatient care patients.[2,3]

HOME HEALTH AGENCIES CONTINUE TO FACE CHALLENGES

Home health agencies (HHAs) play a critical role in the care continuum, including for Medicare beneficiaries following a hospitalization. These providers allow patients to return home safely and continue their recovery while receiving needed nursing, therapy and other care. Hospitals around the country partner with HHAs to ensure the best outcomes for their patients. However, recent reductions in Medicare reimbursement for HHAs are jeopardizing access for these needed services. Specifically, CMS has cut base payments for these providers due to the switch to the new patient-driven grouping model by more than 10% in the last several years and plans to cut billions of dollars more in payment in the near future. These reductions directly impact not only HHAs and their patients, but also hospital operations as hospitals have face increased difficulties with placing patients in HHA care. This, in turn, requires hospitals to care for these patients while awaiting placement, driving up lengths of stay and costs for the entire Medicare program, and hampering the continued recovery of beneficiaries.

CONCLUSION

We look forward to working with Congress to permanently adopt telehealth waivers, extend the H@H program, and support home health agencies. Thank you for your attention to this issue and your consideration of our comments on behalf of hospitals and health systems.

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[2] Caplan G.A., Sulaiman N.S., Mangin D.A., et al. A meta-analysis of "hospital in the home". Med J Aust. 2012 Nov 5;197(9):512-9. doi: 10.5694/mja12.10480. PMID: 23121588. Accessed at https://www.mja.com.au/ journal/2012/197/9/meta-analysis-hospital-home.

[3] Levine D.M., Ouchi K., Blanchfield B., et al. HospitalLevel Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77- 85. doi: 10.7326/M19-0600. Epub 2019 Dec 17. PMID: 31842232. Accessed at https://www.acpjournals.org/ doi/10.7326/ M19-0600.

Statement

of the

Alliance for Home Dialysis

for the

Committee on Ways and Means

of the

U.S. House of Representatives

"Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

On behalf of our coalition of patient groups, clinical societies, dialysis providers, and innovators, the Alliance for Home Dialysis (Alliance) thanks you for the opportunity to submit comments to the House Committee on Ways and Means regarding the important topic of increasing access to home dialysis in America.

The Alliance's mission is to promote policies that facilitate treatment choices—with an emphasis on home dialysis—for individuals in need of dialysis and to address systemic barriers that limit access to the many benefits of home dialysis. Because Medicare covers end-stage kidney disease (ESKD) patients of all ages, not just those 65 and older, Congress has a key role in ensuring choice and quality care.

We believe lawmakers can and should, through a bipartisan, consensus-driven process, use Medicare policy to promote the increased utilization of home dialysis.

Home hemodialysis for ESKD emerged in the early 1960s, and since there was no government funding to pay for treatment at that time, home became an affordable treatment option for patients. In the early '70s, Congress passed the Social Security Amendments of 1972 (P.L. 92-603) that extended Medicare coverage to individuals with ESKD who need either dialysis or transplantation to maintain life, regardless of age.

Congress' stated intent in the creation of the end-stage renal disease (ESRD) benefit was that "the maximum practicable number of patients who are medically, socially, and psychologically suitable candidates for home dialysis or transplantation should be so treated."[1]

In 1973, about 40 percent of dialysis patients in the U.S. practiced home hemodialysis. However, the percentage of patients who dialyze at home has since decreased to just over 13 percent.[2]

Home dialysis has clear advantages for patients with ESKD. The average ESKD patient receiving in-center dialysis spends between 3-5 hours, 3 times a week dialyzing. ESKD patients are on dialysis for the rest of

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[1] Section 1881(c)(6) of the Social Security Act.

[2] United States Renal Data System. 2022 *USRDS Annual Data Report: Epidemiology of kidney disease in the United States.* National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2022. https://usrds-adr.niddk.nih.gov/2022

their lives, or until transplanted. This treatment is lifesaving, but the significant burden it places on patients presents real challenges for individuals and their families, especially those living in rural or underserved areas. Further, the quality-of-life advantages of home modality are clear—improved survival rates, significantly more flexibility for patients, the potential to experience fewer dialysis side effects, and even increased options for employment and education, compared to in-center dialysis.

The Government Accountability Office's (GAO) data (from early ten years ago) suggests that barriers remain for optimizing home dialysis's availability and utilization, and GAO estimates that up to 25 percent of dialysis patients could realistically dialyze at home.[3]We believe that this number is even higher today due to advances in medical technology, a large increase in the number of patients needing dialysis, and increased demand for home therapies and may be worth revisiting.

We believe that lawmakers could improve home dialysis rates by adopting polices that:

- remove current restrictions that prevent acute kidney injury (AKI) patients from having access to home dialysis;
- promote primary care interventions upstream including expanding access to appropriate screening for chronic kidney disease (CKD) and ESKD;
- expand access to kidney disease education (KDE) services; and,
- collect and analyze Medicare Advantage ESKD data, including home dialysis data, to better inform future policy and lawmaking.

Thank you for your work to improve the lives of ESKD patients by covering necessary treatment for life-saving care through Medicare. We look forward to continuing to work with you to improve the quality of life and health outcomes for all Americans with ESKD.

[3] Government Accountability Office. (2015). End-Stage Renal Disease: Medicare Payment Refinements Could Promote Increased Use of Home Dialysis. (GAO Publication No. 16-125). Washington, D.C.: U.S. Government Printing Office.

Alzheimer's Association and Alzheimer's Impact Movement Statement for the Record

United States House Committee on Ways and Means Hearing on "Enhancing Access to Care at Home in Rural and Underserved Communities"
March 12, 2024

The Alzheimer's Association and Alzheimer's Impact Movement (AIM) appreciate the opportunity to submit this statement for the record for the United States House Committee on Ways and Means hearing on "Enhancing Access to Care at Home in Rural and Underserved Communities." The Association and AIM thank the Committee for its continued leadership on issues important to the millions of people living with Alzheimer's and other dementia and their caregivers. This statement emphasizes the importance of the preservation and expansion of telehealth in order to enhance access to care in rural and underserved communities.

Founded in 1980, the Alzheimer's Association is the world's leading voluntary health organization in Alzheimer's care, support, and research. Our mission is to eliminate Alzheimer's and other dementia through the advancement of research, to provide and enhance care and support for all affected, and to reduce the risk of dementia through the promotion of brain health. AIM is the Association's advocacy affiliate, working in a strategic partnership to make Alzheimer's a national priority. Together, the Alzheimer's Association and AIM advocate for policies to fight Alzheimer's disease, including increased investment in research, improved care and support, and the development of approaches to reduce the risk of developing dementia.

Expansion of Telehealth Service Coverage

The Alzheimer's Association and AIM are grateful that the Centers for Medicare & Medicaid Services (CMS) permanently expanded Medicare and Medicaid coverage for many telehealth services important to persons living with dementia and caregivers. For example, CMS has permanently expanded coverage for numerous codes that are beneficial to people living with Alzheimer's and other dementia so that they can continue accessing care in settings that best serve their unique needs. In particular, the Alzheimer's Association and AIM supported CMS's decision to allow for telehealth coverage of care planning CPT® code 99483. Care planning is critical for people with cognitive impairment under normal circumstances to help them manage comorbid conditions and make decisions about long-term care and support services, among others. Ensuring that a plan is established, documented, and updated is now more important than ever. Making this service available via telehealth will improve access to care planning for this vulnerable population. To that end, we also thank Congress for passing the bipartisan *Improving HOPE for Alzheimer's Act* (P.L.116-260), which continues to educate clinicians on the importance and availability of this crucial Medicare care planning service.

Finally, we appreciate CMS's flexibility in allowing telehealth technology to be used in home health delivery. Thirty-two percent of individuals using home health services have Alzheimer's or other dementia. The ability to receive care in the home decreases visits to unfamiliar places that may cause agitation in people with dementia and can ease some burden on caregivers. Additionally, it provides a sustained option for care for people in rural areas with medical deserts. They now have reduced barriers to care, which helps both people living with Alzheimer's and other dementias and their families and caregivers. This increased flexibility can reduce interruptions in access to quality health care.

Expanding Capacity for Health Outcomes (Project ECHO)

Quality care delivered by trained providers leads to better health outcomes for individuals and caregivers, and puts less strain on health systems. Yet, too often overburdened primary care providers are unable to access the latest patient-centered dementia training. First, we ask that the Committee recognize the importance of the expansion of and continued investment in the use of technology-enabled collaborative learning and capacity-building models, often referred to as Project ECHO. These models use a hub-and-spoke approach by virtually linking expert specialist teams at a 'hub' with the 'spokes' of health providers in local communities to increase on-the-ground expertise. Using case-based learning, Project ECHO models can improve the capacity of providers, especially those in rural, frontier, and underserved areas, on how to best meet the needs of people living with Alzheimer's and other dementia. In 2018, the Alzheimer's Association launched an Alzheimer's and Dementia Care Project ECHO Network – a highly successful telementoring program that has trained more than 450 health care professionals from 170 primary care practices and more than 350 professional care providers from 140 long-term care communities in a free continuing education series of interactive, case-based video conferencing sessions across the United States.

Project ECHO dementia models are helping primary care physicians in real-time understand how to use validated assessment tools appropriate for early and accurate diagnoses, educate families about the diagnosis and home management strategies, and help caregivers understand the behavioral changes associated with Alzheimer's. Participants express high levels of satisfaction with the program and the majority (95 percent) of primary care clinicians who join the Alzheimer's and Dementia Care ECHO program said the quality of care they provide improved as a result of their experience. Long-term and community-based care providers also benefit from Project ECHO dementia programs. Recent evaluations from the Alzheimer's Association demonstrate statistically meaningful increases in confidence in working with people living with dementia and overall disease knowledge post-ECHO completion and 92 percent of long-term care participants felt that the information gained through participation was valuable in their work.

In 2020, the Alzheimer's Association launched the Alzheimer's and Dementia Care ECHO Global Collaborative. We are engaging partners across the world using the ECHO model to increase equitable access to dementia detection and person-centered dementia care. This group meets quarterly and has identified three key working objectives: (1) increase the use of Project ECHO for Alzheimer's and other dementia care; (2) increase evidence around the efficacy of the ECHO

model for dementia; and (3) increase and advance policy and funding support for ECHO programs focused on dementia. This robust network currently includes 18 partners spanning four continents, with nine additional organizations exploring the ECHO model for dementia.

One partner in the Alzheimer's and Dementia Care ECHO Global Collaborative is the Dementia ECHO Indian Country Program. The Indian Country Program is designed to support clinicians at the Indian Health Service and caregivers to strengthen the knowledge and care around dementia tribal patients. These ECHO programs are interactive online learning environments where clinicians and staff serving American Indian and Alaska Native patients connect with peers, engage in didactic presentations, collaborate on case consultations, and receive mentorship from clinical experts from across Indian Country.

Project ECHO was especially crucial during the COVID-19 pandemic, where the models played an important role in how health providers, public health officials, and scientists in real-time share best practices and information. For example, the Agency for Healthcare Research and Quality (AHRQ) established the AHRQ ECHO National Nursing Home COVID-19 Action Network (Network) of over 100 ECHO hubs to train nursing home staff on COVID testing, infection prevention, safety practices to protect residents and staff, quality improvement, and how to manage social isolation. The Network received nearly $237 million in federal funding during the pandemic, and, as a result, was able to reach nearly two-thirds of nursing homes in the United States. As a result, these ECHO programs enable primary care providers to better understand Alzheimer's and other forms of dementia, emphasize high-quality, person-centered care in community-based settings, and aim to improve health outcomes while reducing geographic barriers and the cost of care through a team-based approach. Investing in Project ECHO models is an innovative way to improve the capacity of a quality healthcare workforce to meet the needs of a growing aging population, including primary care physicians, specialists, and long-term care workers.

Conclusion

The Alzheimer's Association and AIM appreciate the steadfast support of the Committee and its continued commitment to advancing legislation important to the millions of families affected by diseases such as Alzheimer's and other dementia. We look forward to working with the Committee and other members of Congress in a bipartisan way to advance policies in rural, frontier, and underserved areas that would help people living with Alzheimer's and other dementia receive consistent, high-quality health care.

March 26, 2024

The Honorable Jason Smith
Chair
U.S. House of Representatives
Ways and Means Committee
1011 Longworth House Office Building
Washington DC, 20515

The Honorable Richard Neal
Ranking Member
U.S. House of Representatives
Ways and Means Committee
372 Cannon House Office Building
Washington DC, 20515

Dear Chair Smith, Ranking Member Neal, and Members of the House Ways & Means Committee, APhA appreciates the opportunity to submit the following statement for the record for the House Ways and Means Committee, "Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities."

APhA is the largest association of pharmacists in the United States advancing the entire pharmacy profession. APhA represents pharmacists and pharmacy personnel in all practice settings, including community pharmacies, hospitals, long-term care facilities, specialty pharmacies, community health centers, physician offices, ambulatory clinics, managed care organizations, hospice settings, and government facilities. Our members strive to improve medication use, advance patient care, and enhance public health.

APhA applauds you for conducting this very important hearing to address ways to enhance access to care in rural and underserved communities. This is especially critical now that the need for health care providers has increased across the country, while the availability of trained providers has simultaneously decreased, creating health care disparities. Pharmacists have been at the forefront of this issue by offering patients the ability to access a highly trained health care provider, especially in rural and underserved areas.

This was especially evident during the COVID-19 public health emergency (PHE) when pharmacists demonstrated the ability to significantly expand access and equity to health care. The pandemic has demonstrated how essential and accessible pharmacists are in the United States. While many communities across the country do not have access to a primary care provider, more than 90% of Americans live within 5 miles of a pharmacist. A strong body of evidence has shown that including pharmacists on interprofessional patient care teams with physicians, nurses, and other health care providers produces better health outcomes and cost savings. As a result, lifting barriers to access is essential as we continue to look for ways to improve patient access to critical health care services.

During the pandemic, pharmacists and pharmacies were able to test, treat, and immunize patients for conditions ranging from COVID-19 to the flu. The flexibilities offered by the federal government made access to health care easier for pharmacists to provide care to patients during the PHE. The problem is many of these flexibilities and authorities are not permanent and further action is needed to preserve access to pharmacist-provided services. We ask for the Committee to pass legislation removing any barriers that would prevent patients from receiving, and pharmacists from providing, these essential patient-care services as part of the health care team.

To illustrate this urgency, U.S. Department of Health and Human Services (HHS) Secretary Xavier Becerra recently lengthened the PREP Act authority for pharmacists and pharmacy technicians to administer COVID-19 vaccines and tests, along with flu vaccines until December 2024. Without this extension, that authority would have expired on May 11, 2023 when the COVID-19 health emergency officially ended and these federal authorities are still set to expire again in December.

The extension of authority and the Secretary's recognition of pharmacist services was a critical step, however, with the federal government's clear reliance on pharmacists as a vital part of our nation's public health infrastructure, more must be done to preserve patients' access to care.

In addition, HHS also recognized the value of bringing vaccinations to communities that lack health care providers and provided additional reimbursement for pharmacists and other practitioners during the PHE to bring certain Part B vaccines (COVID-19, Flu, Hepatitis B, Pneumococcal) to patients in their homes. HHS and the Centers for Medicare and Medicaid Services (CMS) have continued this practice for 2024. APhA strongly recommends the Committee pursue legislation to make this very successful public health measure permanent and apply it to all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines. Studies definitively show that vaccination is one of the most cost-effective interventions that contribute to health care system efficiency.

One step the Committee can take immediately is enacting H.R. 1770 the Equitable Community Access to Pharmacists Services Act (ECAPS), led by Representatives Adrian Smith (R-NE) and Brad Schneider (D-IL). and many others on this Committee. along with 110 bipartisan cosponsors. This legislation would provide for Medicare Part B coverage for pharmacists' services for common respiratory conditions, including the testing of COVID-19, flu, RSV, and strep; treatment of COVID-19, flu, RSV, and strep; and the vaccination of COVID-19, flu, and Hepatitis B – which, if passed into law, will allow seniors to receive health care closer to home and save billions of dollars in avoidable hospitalizations and millions of lives.

We know from the data that public health interventions by pharmacists and teammates averted >1 million deaths, >8 million hospitalizations, and saved over $450 billion in health care costs. Patients have come to expect that they can access these vital health

care services at their local pharmacy, particularly in underserved communities, where the neighborhood pharmacy may be the only health care provider for miles.

Despite the fact that many states and Medicaid programs are turning to pharmacists to increase access to health care, Medicare Part B does not cover many of the vital patient care services pharmacists are trained to provide. As proven during the pandemic, pharmacists are an underutilized and accessible health care resource who can positively affect beneficiaries' care and the entire Medicare program.

H.R. 1770 would enable Medicare patients to better access health care through state-licensed pharmacists practicing according to their own state's scope of practice. Helping patients receive the care they need, when they need it, is a common sense and bipartisan solution that will improve outcomes and reduce overall costs.

As you look for ways to increase patient access to health care in rural areas, we urge you to pass H.R. 1770. Thank you for the opportunity to comment on this hearing and express our concerns to the Committee. We would once again like to commend you for your leadership on these issues and would be happy to assist in any manner we can. Please contact Doug Huynh, JD, APhA Director of Congressional Affairs, at dhuynh@aphanet.org if you have any additional questions.

Sincerely,

Michael Baxter

Michael Baxter
Vice President, Federal and State Legislative Affairs

March 25, 2024

The Honorable Jason Smith
Chair
House Ways and Means Committee
1139 Longworth House Office Building
Washington, D.C. 20515

Re: House Ways and Means Committee Hearing, "Enhancing Access to Care at Home in Rural and Underserved Communities"

Dear Chairman Smith:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association submits the following comments in response to the Ways and Means Committee hearing, "Enhancing Access to Care at Home in Rural and Underserved Communities." APTA is dedicated to building a community that advances the physical therapy profession to improve the health of society. As experts in rehabilitation, prehabilitation, and habilitation, physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability for individuals across the age span, helping individuals improve overall health and prevent the need for avoidable health care services. Physical therapists' roles include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession's vision of transforming society by optimizing movement to improve the human experience.

"The Economic Value of Physical Therapy in the United States," a recently released APTA report, showcases the cost-effectiveness and economic value of physical therapist services for a broad range of common conditions. The report compares physical therapy with alternative care across a suite of health conditions commonly seen within the U.S. health care system. The report underscores and reinforces the importance of including physical therapists and physical therapist assistants as part of multidisciplinary teams focused on improving patient outcomes and decreasing downstream costs. The committee should consider the insights provided in this report to support access to, coverage of, and payment for physical therapist services, and to support policies that position physical therapists as entry-point providers to ensure beneficiaries have timely access to proven, cost-effective care.

As digital health technologies, including telehealth, expand into the health sector, physical therapists' and physical therapist assistants' access to these delivery tools should be considered in decisions regarding payment, coverage, broadband, and technology infrastructure policies. For example, the APTA report demonstrates that physical therapy-based cancer telerehabilitation programs deliver a net cost-benefit of approximately $4,000 per episode of care.

In the 118th Congress, APTA is supporting several legislative initiatives to expand patient access to physical therapy care in the rural and medically underserved areas, especially proposals to continue the delivery of care via telehealth. To permanently include physical therapists and physical therapist assistants as authorized telehealth providers in Medicare, APTA strongly endorses the bipartisan Expanded Telehealth Access of Act of 2023 (H.R. 3875/S. 2880). Separately, APTA is endorsing H.R.

7623 – the Telehealth Modernization Act – which proposes to make many of the pandemic-era telehealth flexibilities permanent.

The expansion of telehealth payment and practice policies under the Section 1135 waivers during the public health emergency, including permitting physical therapist services to be furnished via telehealth by PTs and PTAs across settings, has demonstrated that many health care needs can be safely and effectively met and that patients can have improved access to skilled care by leveraging these resources. This has been especially beneficial for those patients residing in rural areas who often have access to far fewer providers than other regions and may live a very considerable distance from medical facilities and other health care professionals.

Physical therapists and physical therapist assistants use telehealth as a supplement to in-person services to evaluate and treat a variety of conditions prevalent in the Medicare population, including but not limited to Alzheimer's disease, arthritis, cognitive/neurological/vestibular disorders, multiple sclerosis, musculoskeletal conditions, Parkinson disease, pelvic floor dysfunction, frailty, and sarcopenia.

Physical therapists make determinations, in consultation with patients and caregivers, regarding the appropriate mix of in-person and telehealth services to meet the goals in the plan of care. The evaluation and treatment of a patient via the use of telehealth allows the physical therapist to interact with the patient within the real-life context of their home environment, which is not easily replicable in the clinic. Patient and caregiver self-efficacy are inherent goals of care, and telehealth not only allows a physical therapist to maintain the continuity of care anticipated in the plan of care, but also allows for immediate and effective engagement when a specific challenge arises.

Skilled physical therapist interventions delivered through an electronic or digital medium have the potential to prevent falls, functional decline, costly emergency room visits, and hospital admissions and readmissions. Further, physical therapists already are experienced in modifying exercises for the patient to perform them safely at home, as a home exercise program is a common element of a treatment plan for patients who are treated in person. Examples of PTs and PTAs using telecommunications technology to provide real-time, interactive care include the following:

- Physical therapy practitioners use telehealth technologies to conduct evaluations or reevaluations or provide quicker screening, assessment, and referrals that improve care coordination.
- Physical therapy practitioners provide interventions using telehealth by interacting with the patient in real time to provide instruction in exercise and activity performance; observe return demonstration and offer instruction in modifications or progressions of a program; provide caregiver support; and promote self-efficacy.
- Physical therapy practitioners provide verbal and visual instructions and cues to modify how patients perform various activities. They also may suggest that the patient or caregiver modify the environment for safety reasons or to potentially produce even more optimal outcomes.
- Physical therapy practitioners use telehealth technologies to provide prehabilitation and conduct home safety evaluations.
- Physical therapy practitioners use telehealth technologies to observe how patients interact with their environment and/or other caregivers, and to provide caregiver education.

- Physical therapy practitioners can assess the influence of activity modification strategies and activities to determine effectiveness immediately rather than waiting for the next in-person visit.

- Physical therapists use telehealth to reduce the number of in-clinic visits and still maintain important follow-up care. This might reduce travel time and/or burden for a patient, which, for some conditions, might result in faster healing. This also prevents any delays in modifying a program when it needs to be upgraded or downgraded.

- Physical therapists can use technology to satisfy supervision requirements.

- A physical therapist can co-treat with another clinician who is treating via real-time audio and visual technology.

- A treating physical therapist can consult directly with another physical therapist or physical therapist assistant for collaboration and/or to obtain specialty recommendations to incorporate into an existing plan of care.

- Physical therapists use telehealth for quick check-ins with established patients.

Policy Recommendation

APTA supports the ability of Medicare beneficiaries in rural and underserved areas to maintain the option, when appropriate, to have physical therapist services provided via telehealth. Permitting services to be furnished via telehealth by PTs and PTAs has provided greater options for patients to access care. APTA strongly urges Congress to enact legislation to maintain the current policy and add physical therapists and physical therapist assistants as permanently authorized telehealth providers under Medicare before the expiration of the current waiver on Dec. 31, 2024.

We appreciate the opportunity to share our perspectives on this issue. Should you have any questions, please contact APTA Congressional Affairs Specialist Steve Kline at stevekline@apta.org. Thank you for your time and consideration.

Sincerely,

Roger Herr
President, American Physical Therapy Association.

Avera

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Statement for the Record:
"Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities"
U.S. House of Representatives
Ways and Means Committee

As Chairman Smith said in his opening statement, "For patients in rural and underserved communities, bringing health care home is a lifesaver." We at Avera Health agree and ask the Committee to please continue their support of the Hospital at Home (H@H) program. Avera McKennan Hospital and University is located in Sioux Falls, South Dakota and serves as the primary tertiary care center for approximately 87 counties in the upper Midwest including portions of Minnesota, South Dakota, Iowa, and Nebraska. Excluding Sioux Falls, most of the 87-county service area is designated as either rural or frontier. Since the pandemic, Avera McKennan has experienced unprecedented hospital capacity issues. These capacity issues have resulted in rural hospitals having to keep higher acuity patients in their facilities without access to the corresponding higher acuity care that patients need. While this continues to be an on-going problem, it has been alleviated to some extent by the CMS Hospital at Home waiver program.

Our health system is writing this letter to request at least a 5-year extension of the Acute Hospital Care at Home waiver program before its expiration at the end of 2024. Without an extension, Medicare beneficiaries will lose access to CMS Hospital at Home programs that have demonstrated excellent clinical outcomes and lower the costs of care. The H@H model allows healthcare professionals to understand the challenges that patients face in their everyday life before they are discharged. The insight into what is happening with patients clinically and how their home environment impacts their care outcomes is critical in improving patients' long-term health. Furthermore, the model has a clear impact on our rural hospitals' ability to transfer high acuity patients to the most appropriate setting.

Medicare created the Hospital at Home waiver at the height of the COVID-19 pandemic as part of a broad strategy to help alleviate hospital capacity issues. Prior to the implementation of the Hospital at Home waiver, approximately 20 H@H programs existed across the U.S. After the waiver, more than 300 hospitals across 129 health systems in 37 states are operating under the waiver—with no guarantee of payment permanence. That represents approximately 5% of all U.S. hospitals and 15% of academic medical centers. Clinical outcomes of the program have been outstanding. At this current trajectory, 1 in 6 hospitals will have H@H by 2030, allowing hospital care to be delivered to more patients in the safety and comfort of their homes nationwide.

Hospital at Home has a long history. Over the past 30-plus years, H@H researchers have found through numerous studies that patients and family caregivers prefer H@H, which delivers excellent clinical outcomes, including substantial reductions in adverse events (e.g., mortality), better patient and family experience, lower caregiver stress, better functional outcomes, high provider satisfaction, and lower costs of care. As a result of these studies, we believe that the Hospital at Home waiver, which provides

appropriate payment for acute hospital-level care delivered at home, is the keystone to the future of home-based care delivery for Medicare patients and beyond.

Avera McKennan in conjunction with Avera @Home submitted a request under the CMS acute hospital care at home initiative waiver, approved in July 2021. As of February 2024, the number of patients that have been cared for in Avera's Hospital@Home program equals 282 patients and amounted to 601 additional bed days.

Our quality, safety and patient satisfaction scores are excellent and remain a top priority. The patient satisfaction scoring tool utilized by Avera McKennan is Press Gainey. Please see below for examples of patient stories.

Examples of patient comments are as follows:

- February 2024 Patient Comment, "I prefer the hospital in home care program – you get to sleep in your own bed and a better sleep when at home. You are in your own surroundings you can lay down in your own bed or couch or just rest in your own chair."
- October 2023 Patient Comment: "Hospital to home was an amazing experience and a great help to me."
- March 2024: Patient comment when setting up follow-up services by Avera@Home care transitions: "H@H program changed her life. She loved being at home and sleeping in her own bed and she continues to not smoke!! She said it helped her physically, mentally and spiritually. The patient said she could not stop saying enough wonderful things and was so thankful."

Recommendations and challenges that Hospital at Home faces from a regulatory standpoint:

1. The current CMS waiver requires that Hospital at Home patients meet CMS inpatient criteria. Allowing Observation as a status would be appropriate and impactful for H@H. For example, there are patients who are in the hospital for 1 – 2 days that do not meet inpatient criteria but would still benefit from hospital at home. From a rural hospital perspective, a change in criteria would free up hospital beds for more critical patients as additional testing and treatment are initiated for others.
2. Currently, a patient can only be admitted after coming into an emergency department or relocated (Rebed) from an existing inpatient stay. Adding the ability to admit directly to H@H after being seen in a clinic by their physician would be better for all of those involved.
3. Medication requirements that mirror hospital rules should be reviewed for practical 'home setting' reasons, and to reduce waste. By making some slight changes, medication safe distribution standards could be maintained in a more practical way.

We greatly appreciate the Committee's leadership in ensuring stable and sustainable access to care, particularly for rural and underserved communities. We look forward to working with Congress to adopt policies that support the Hospital at Home program. Thank you again for your attention to this issue and your consideration of our comments. Please contact Cate Davis, Public Policy Manager for Avera Health at cate.davis@avera.org or (605) 413-6017 with any questions or concerns.

BlueCross BlueShield Association

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Statement for the Record

Submitted to U.S. House Committee on Ways and Means, Subcommittee on Health

"Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

By: David Merritt, Senior Vice President of Policy and Advocacy

The Blue Cross Blue Shield Association (BCBSA) believes everyone should have access to affordable health care, no matter who you are or where you live, and we share your ongoing commitment to improving access to health care in rural and underserved areas. We thank the Chairman and Ranking Member for holding this important hearing to discuss how innovation can improve health care access and drive better health outcomes in the Medicare program. We also thank the Committee for their work on H.R. 5783, the Lower Costs, More Transparency Act, which contains two key provisions in Sections 201 and 204 that will lower costs for patients through greater transparency in hospital billing practices and modest site-neutral reforms to physician-administered drugs.

BCBSA is a national federation of independent, community-based and locally operated Blue Cross and Blue Shield (BCBS) companies (Plans) that collectively cover, serve and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 96% of hospitals and 95% of doctors across the country and serve those who are covered through Medicare, Medicaid, an employer or purchase coverage on their own. We are committed to delivering affordable and equitable access to high-quality care for every American.

BCBSA and BCBS companies are taking strong action to meaningfully address health disparities in rural and underserved areas, working to create a more equitable health care system for all. These initiatives include significant investments and innovative partnerships with technology leaders to improve member experiences while empowering members and providers alike to make informed health care decisions with powerful data insights. One of the most effective ways to improve care in rural and underserved areas is through technology. Below are some examples of how BCBS Plans are leveraging data and technology

to expand access to care for all patients, drive personalized patient care plans and provide more seamless, connected care:

- Highmark Health announced a collaboration with Epic and Google Cloud to integrate its insights into providers' existing Epic workflows, giving clinicians a more complete view of patients' health, enable faster decision-making and improve quality of care. These integrated improvements will provide better experiences for consumers and clinicians while improving health outcomes and lowering costs.
- BCBS Michigan unveiled a new behavioral health navigation tool, made in collaboration with Quartet Health, to help members more easily find providers best suited for their mental health or substance use needs. After completing a self-referral, the Quartet platform recommends outpatient providers to users based on their clinical needs and preferences, including the provider's specialty, location and availability.
- BCBS Plans in Illinois, Montana, New Mexico, Oklahoma and Texas have created an innovative Population Health Analytics & Research Tool (PopART) that generates insights into members' potential care needs. PopART helps clinical teams identify where care is most needed by displaying essential health and demographic features at the ZIP code-, member- and community levels in a digestible heat map.
- Blue Shield of California recently announced a collaboration with Microsoft to bring together member, provider and payer data into a data hub that runs on Microsoft Azure cloud platform. This creates a consolidated, real-time view of data to streamline health care decision making and make health information actionable.
- Blue Cross Blue Shield of Massachusetts introduced a new primary care option where a "Virtual Care Team" allows members to receive comprehensive virtual services that include dedicated primary care providers who can treat certain mental health issues and provide personalized health coaching.

BCBSA also is leading innovative payment models through the development of Blue Distinction® Specialty Care, our national centers of excellence program. This program designates high-performing providers that adhere to high standards of quality by delivering safe, effective and cost-efficient care. The program focuses on 11 high-impact, complex care areas: bariatric surgery, cancer care, cardiac care, cellular immunotherapy-CAR-T, fertility care, gene therapy-ocular disorders, knee and hip replacement, maternity care, spine surgery, substance use treatment and recovery and transplants. More than 5,370 Blue Distinction Specialty Care designations have been awarded to nearly 2,500 provider facilities across the country. The results are impressive: patients treated by Blue Distinction Specialty Care providers have better outcomes, fewer complications, lower readmission rates and save more than 20% on average.[1]

[1] Internal BCBSA analysis of BCBSA and registry data: BDC/BDC+ eligible providers vs. relevant comparison group. Results based on most recent designation cycle for each specialty. Savings based on BDC/BDC+ total episode cost.

Starting this year, designated Blue Distinction Centers for Maternity Care across the country met enhanced quality measurement standards and data from BCBSA shows that designated facilities outperformed national averages in the following areas:

- 17% fewer cesarean births
- 60% fewer elective deliveries
- 26% fewer episiotomies

To further advance maternity care, Blue Cross Blue Shield Association in partnership with the National Quality Forum, is developing a process to evaluate risk appropriate maternity care at facilities based on their Level of Maternal Care.[2] This will create a standardized method to ensure that a facility has the resources, staff, equipment, and processes in place to care for a member's specific needs and risk level. Awareness of a facility's Level of Maternal Care enables perinatal regionalization, leading to lower maternal morbidity and mortality by providing a framework for care coordination within the healthcare system to place BCBS members at the facility best suited for their specific maternal health needs – from basic to high-risk. This is important in rural and underserved areas where maternity care deserts may exist, and where collaboration across facilities with different levels of maternal care are important for these facilities to learn from one another and provide education and training within the region to maintain skills and competency needed when delivery volumes are low.

BCBS companies are driving technology, investing in effective programs and piloting innovations that improve access to care and reduce costs for rural and underserved communities. Congress also can make meaningful policy changes to foster innovation and improve health care access in rural and underserved areas.

BCBSA offers the following recommendations to Congress for improving health outcomes in rural and underserved populations:

Enacting Site-Neutral Payment and Honest Billing Reforms. BCBSA encourages Congress to enact federal legislation to standardize payments for identical services provided in a physician's office and hospital outpatient departments (HOPDs). To accomplish this, Congress should eliminate the grandfathering provision of the Bipartisan Budget Act (BBA) of 2015, which today exempts certain HOPDs from site-neutral payments. An independent analysis of this proposal estimated federal savings of $231 billion over 10 years. The analysis also estimated $152 billion in lower out-of-pocket costs for consumers (about $470 per person in the U.S.) and spillover savings to private insurance that would

[2] "Levels of Maternal Care." American College of Obstetricians and Gynecologists, Accessed March 12, 2024. https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/08/levels-of-maternal-care.

reduce premiums by $117 billion.[3] Changing payment rates in Medicare will help commercial plans negotiate more aggressively to lower costs for patients and employers.

Additional studies have highlighted the potential for significant savings if expanded as well as the limited impact of existing site-neutrality policies on rural outpatient providers. For example, a recent study by Avalere reports that only 2.3% of hospital outpatient revenues are subject to the site-neutral provisions of the 2015 law. An additional 10% of revenues would be affected if the grandfathering provisions were removed.[4] The study also notes that rural hospitals account for a much smaller share of Part B spending than do urban hospitals (10.8%) and that rural hospitals make much less use of off-campus provider-based departments (PBDs) than urban hospitals: Of all payments made to "…off-campus PBDs, rural hospitals represent 7.6% of payments to excepted off-campus PBDs [where the site-neutral policy does not apply] and 6.2% of payments to non-excepted off-campus PBDs."[5] Applying site-neutral payment policies as Congress intended would impact rural hospitals much more modestly than urban hospitals. BCBS Plans also see a lack of site-neutral payment in our own commercial claims data. Two studies of outpatient services conclude that prices for services delivered in HOPDs are significantly higher — often five times more expensive — than when provided in an independent physician's office.[6] These studies also find that HOPD prices are growing much faster than prices in other settings.

Promote Workforce and Care Integration. BCBSA supports investment and expansion of educational pipeline programs and increased integration of behavioral health and primary care to address barriers for rural and underserved communities. BCBSA supports Reps. Michelle Steel (R-CA-45) and Dan Kildee's (D-MI-08) COMPLETE Care Act (H.R. 5819), which improves access to mental health care for seniors on Medicare by covering certain startup costs for local providers as they implement integrated care models.

Permanently Extend Certain Telehealth Flexibilities. As policymakers consider a permanent expansion of telehealth pandemic provisions, we recommend flexibility to address the care needs of each community, while enhancing trust and consumer protection against fraud and abuse through HIPAA-aligned privacy protections. BCBSA supports Sections 101 and 102 of Reps. Mike Thompson (D-CA-04) and David Schweikert's (R-AZ-01) CONNECT for Health Act (H.R. 4189), which remove geographic and originating site restrictions, enabling patients to access care in the comforts of their homes regardless of their geographic location. BCBSA also urges Congress to accelerate investments made in broadband and

[3] Blue Cross Blue Shield Association. "Affordability Solutions for the Health of America." Blue Cross Blue Shield, January 24, 2023. https://www.bcbs.com/the-health-of-america/articles/affordability-solutions-white-paper, EHP_Savings_Estimates_BCBSA_01.18.2023_Final.pdf.
[4] Avalere, "CMS Site-Neutral Payments Affect Small Share of Spending," January 10, 2024, https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending.
[5] Avalere, "CMS Site-Neutral Payments Affect Small Share of Spending," January 10, 2024, https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending.
[6] Blue Health Intelligence, "Costs for Common Health Care Procedures Significantly Higher When Performed in Hospital Outpatient Departments," September 14, 2023, https://www.bcbs.com/sites/default/files/file-attachments/site-neutral/BHISite-Neutral-Issue-Brief.pdf; Blue Health Intelligence, "Hospital Outpatient Prices Far Higher, Rising Faster than Physician Sites," December 14, 2023, https://avalere.com/insights/cms-site-neutral-payments-affect-small-share-of-spending.

data infrastructure for rural and underserved areas to better enable telehealth and remote patient monitoring to meet the needs of communities with provider access challenges.

Strengthen Access and Innovation in Medicare Advantage (MA). BCBSA supports policy solutions that allow MA plans to invest in and better serve rural and underserved communities. BCBSA also encourages the development of innovative payment models targeted to rural populations that focus on improving value-based payment designs. BCBSA supports Reps. Gus Bilirakis (R-FL-02) and Earl Blumenauer's (D-OR-03) Addressing Whole Health in Medicare Advantage Act (H.R. 5746), which expands the definition of enrollees to allow MA plans to offer targeted supplemental benefits to address a variety of risk factors that impact seniors' health. We are committed to efforts that effectively leverage new modes of care delivery, such as telehealth and remote patient monitoring, to increase patient access, quality and value. Specifically, BCBSA supports the use of innovative technologies such as wearable devices and other digital tools like sensors and mobile medical solutions, to improve health outcomes. We encourage the Committee to continue to engage with plans and the broader health care community on this critical priority, with particular focus towards reimbursement, data integration and provider engagement.

Conclusion

BCBSA commends the Committee for holding today's important hearing. We look forward to working with Congress to advance health care access, quality and affordability in rural and underserved areas. If you have any questions or want additional information, please contact Keysha Brooks-Coley, Vice President of Advocacy, at Keysha.Brooks-Coley@bcbsa.com.

David Merritt

Senior Vice President, Policy & Advocacy
Blue Cross Blue Shield Association

March 26, 2024

Submitted electronically via email toWMSubmission@mail.house.gov**.**

The Honorable Jason Smith
United States Representative
1011 Longworth House Office Building
Washington, DC 20510

RE: Enhancing Access to Care at Home in Rural and Underserved Communities

Beth Israel Lahey Health (BILH) appreciates the opportunity to provide comments about the opportunities and challenges to enhancing access to care in patients' homes. BILH is a healthcare system with 14 hospitals, including Academic Medical Centers, small community hospitals and a behavioral health hospital, providing care to over 1.7 million patients in Eastern Massachusetts and Southern New Hampshire. As a result of the flexibilities initially put in place by the Centers for Medicare & Medicaid Services (CMS) during the COVID-19 pandemic and subsequently extended through legislation, BILH has been diligently working to scale up a Hospital at Home program.

The BILH Hospital at Home program (HaH) provides inpatient level care to patients in the comfort and safety of their own homes with outstanding outcomes. We have assembled a highly skilled and dedicated team to manage patients and services telemedically; providing 24/7 care enabled with connected technology and an ecosystem of in person, on demand care services. Our HaH program is focused on caring for patients with diagnosis such as chronic heart failure (CHF), pneumonia, COPD, cellulitis, sepsis, COVID and significantly more complex illnesses. Early anecdotal evidence of our adoption of this model of care has resulted in higher patient satisfaction and, by extension, better clinical outcomes are expected. More importantly, we have seen patients receive the care they need along with the peace of mind that comes with being able to maintain critical family connections and responsibilities; such as the long-time elderly couple where every separation caused deep anxiety in each spouse, or the grandmother raising her grandchildren who worried about their care without her, or the low-income patient who wanted to leave the hospital against medical advice to return to her responsibilities at home.

The waivers provided by CMS, which enabled the necessary flexibilities to the hospital conditions of participation allowing inpatient level of care to be provided in the home setting,

have been critical to the program's success. We hope Congress will further extend these waivers before their expiration on December 31, 2024.

While this program has been very successful and can continue to provide benefits to patient outcomes, reductions in demands on SNF and rehabilitation facilities and deliver long-term cost savings, additional flexibilities will allow for the Hospital at Home program to reach even more patients. As the program exists today, each separately certified hospital must operate its own Hospital at Home program even if the hospital is part of a health system. Within the BILH system, we have found that our smaller hospitals with less specialty resources, often serving more rural or underserved communities, lack the resources and expertise to establish and manage a full scale Hospital at Home program. With additional regulatory flexibility, a health care system like BILH could centrally establish and manage an Acute Hospital Care at Home model at all of our individually certified hospitals (no matter their individual resources). The services of a tertiary or quaternary hospital could be leveraged – and contracted out to a smaller community or rural hospital - to provide comprehensive inpatient (Acute) Hospital Care at Home, and still allow the smaller hospital to maintain connectedness and accountability for the overall care of the inpatient in their local geography. In short, the H@H inpatient would remain an inpatient of the community or rural hospital but the tertiary or quaternary hospital would contract with the community/rural hospital to provide a turnkey package of inpatient hospital level of care services (e.g., nursing, pharmacy, labs, etc.). Hospitals without 24/7 pharmacy, for example, would have difficulty offering HaH. A hospital, if able to share central resources, could readily offer the HaH model to all clinically eligible patients regardless of which hospital the patient presented to, equally sharing capacity and quality benefits for all hospitals, not solely the best resourced hospitals. Without this type of flexibility, patients of smaller, rural communities, may not have the model available to them given the significant resources required to stand up and effectively deliver this model of care. Additionally, this flexibility helps provide access to specialists for patients in hospitals with difficult specialty availability/bandwidth by enabling access to the resources of larger centers, again equalizing access to inpatient specialty care while keeping the patient closer to home.

The capability to support hospitals in rural settings and hospitals with less resources would improve equitable delivery of healthcare and allow us to offer care options to all patients within our system; not solely patients of hospitals with the resources or scale to support a Hospital at Home program independently.

We thank you again for attention you are paying to this important care delivery model and for the opportunity to share our experience and learnings. We look forward to the opportunity to work with you to extend the Hospital at Home program to ensure this model of care is made available to even more patients.

Moving Health Home
An Alliance to Advance Home-based Care Policy

Statement for the Record:
"Enhancing Access to Care at Home in Rural and Underserved Communities"
U.S. House Ways and Means Committee

Moving Health Home
1100 G Street NW, Suite 420, Washington, DC 20005

March 12, 2024

Moving Health Home (MHH) appreciates the opportunity to submit testimony for this hearing on enhancing access to care at home in rural and underserved communities. MHH is a coalition of health care organizations with a bold vision to make the home a site of clinical service. Our members share in the belief that experience during the pandemic has accelerated the day when care in the home is an accessible option for patients.

For our members, clinical care in the home refers to a spectrum of health services provided in the home or place of dwelling outside of a facility, such as hospital-level or acute care, primary care office, skilled nursing and therapy services, and hospice. It can mean a house call from a primary care doctor or nurse, a physical therapy session, a laboratory and diagnostic service, a home infusion, or a full complement of hospital-level services. At the core, we want to remove regulatory barriers to ensure all patients may choose to receive clinical care in the home and take advantage of the convenient, high-quality care that comes when patients receive home-based care.

More than 60 million Americans live in rural areas. On average, rural residents are older and generally have worse health conditions than urban residents. Despite this, rural residents face more barriers to accessing health care like local hospital closures or traveling far for the nearest health care service. Technologies like telehealth and remote patient monitoring support care in the home and reduces barriers to care. MHH believes that broadened access to care in the home has the potential to improve access and outcomes for health care in rural areas. In particular, MHH supports H.R. 2853, The Expanding Care in the Home Act, as introduced by Reps. Smith (R-NE) and Dingell (D-MI).

MHH will focus comments on 1) the need for a five-year extension of the Acute Hospital Care at Home (AHCaH) program; 2) data around Americans wanting to age in place; and 3) the integration of technologies toward a care model where home is a site of clinical service.

Extend the Acute Hospital Care at Home Program

The AHCaH program is a care delivery model that allows some patients to receive acute, hospital-level care in their homes, as opposed to a traditional, in-patient hospital setting. Hospitals that have a Hospital at Home program evaluate patients to determine whether in-home care is appropriate, and while the structure of each program differs, only patients that are stable enough for in-home monitoring are admitted to the home. Monitoring may happen via in-person visits, as well as through remote patient monitoring and telehealth visits. Patients can receive clinically appropriate care in the home, including but not limited to diagnostic procedures, oxygen therapy, intravenous fluids and medicines, respiratory therapy, pharmacy services and skilled nursing.

The AHCaH program is an expansion of the Centers for Medicare and Medicaid Services (CMS) Hospital Without Walls program. Launched in March 2020, the Hospital Without Walls initiative was part of a comprehensive effort to increase hospital capacity, maximize resources, and combat COVID-19 to keep

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Americans safe. The program also allowed additional flexibility that allowed certain health care services to be provided outside of a traditional hospital setting and within a patient's home.

The AHCaH program has been extremely popular, and as of March 2024, there are 131 health systems and 315 hospitals in 37 states participating in the program. The success of the AHCAH waiver builds on decades of evidence generated by acute care at home programs in the United States. Research shows that these programs are at least as safe as facility-based inpatient care and result in improved clinical outcomes, higher rates of patient satisfaction, and reduced health care costs. One study found evidence suggesting AHCaH is an important care model for managing acute illness, including among socially vulnerable and medically complex patients.

On December 29, 2022, the Consolidated Appropriations Act (CAA) for Fiscal Year 2023 (H.R. 2716) included a two-year extension of the AHCaH waiver, which was a product of Representatives Earl Blumenauer (D-OR) and Brad Wenstrup (R-OH) legislation: the Hospital Inpatient Services Modernization Act (S. 3792/H.R. 7053).

MHH and its members urge the Committee to extend the Medicare ACHaH waiver program for at least five years, prior to the expiration on December 31, 2024 to allow for implementation time. Without timely and decisive action from Congress, many Medicare beneficiaries will lose access to ACHaH programs that have been demonstrated to provide excellent clinical outcomes and lower the costs of care.

Seniors Want to Home to Be a Clinical Site of Care

According to the U.S. Census, more than one in five older Americans living in rural areas, many concentrated in states where more than half of their older populations are in rural areas. Despite being the sickest population, they face barriers to health care including transportation difficulties, limited health care supply, and financial constraints. Additionally, many rural older adults, after hospitalization, do not wish to move. Many rural older adults have lived their whole lives in the same small towns, some in the same homes. Allowing home to be a clinical site of care allows older adults to be comfortable in the setting where they receive their clinical care.

Home-based care refers a spectrum of health services provided in the home or place of dwelling, such as hospital-level or acute care, primary care, skilled nursing and therapy services, and hospice. Services may include routine physician visits, chronic disease management (such as remote patient monitoring), laboratory and diagnostic services (such as blood draws and x-rays), home infusion (such as antibiotics), wound care, physical or occupational therapy, in-home dialysis, and other care provided in the home setting rather than a facility, and regardless of age and health conditions.

A national survey found that there is widespread support by adults for receiving care in their homes across the care continuum. Specifically:

- **Americans Are Comfortable Receiving Care in the Home**
  - 70 percent of those surveyed are comfortable with care in the home citing that familiarity helps alleviate anxiety and improve communication. This is especially important for those from underserved and minority communities.
- **Americans Are Confident in the Quality of Receiving Care in the Home**
  - 73 percent of adults are confident in the quality of receiving care in the home.
  - 85 percent of caregivers are confident in the quality of receiving care in the home.

  - 88 percent of adults were satisfied with the clinical care services they received in the home.

- **Americans Prefer and Would Recommend Care in the Home**
  - 85 percent of people who have had experience with care in the home would recommend it to family and friends.

- **Americans Support Expanded Care in the Home**
  - A bipartisan majority of consumers say it should be a priority for the federal government to increase access to clinical care in the home (73 percent Democrats, 61 percent Republicans).

Care in the home models supports older adults that wish to age in place. A survey conducted by AARP found that 77 percent of older adults want to remain in their homes for the long term.

Innovative Models and Technologies Toward Care in the Home

Rural hospitals provide essential health care to rural communities. Yet, over 100 rural hospitals closed from January 2013 – February 2020. When rural hospitals closed, people living in areas that received health care from them had to travel farther to get the same health care services—about 20 miles farther for common services like inpatient care or even face delays in discharges from emergency and inpatient care. Innovative models and technologies can help connect care for Medicare beneficiaries living in rural and underserved communities and allow them to receive care from their homes.

Skilled Nursing Facility at Home

Skilled Nursing Facility (SNF) at home is the option of receiving SNF-level services in the home that otherwise would have been provided in a facility. The creation of a SNF-at-Home program would allow patients to access these services from the home using a mix of skilled care, personal care, and telehealth services.

Skilled nursing facilities primarily provide inpatient skilled nursing care and related services to patients who require medical, nursing, or rehabilitative services, but does not provide the level of care or treatment available in a hospital. Medicare pays SNFs a predetermined amount per day that a beneficiary receives care, up to 100 days.

According to data from 2019 and 2020, total Medicare SNF spending increased $1.1 billion (4.4 percent), despite 200,000 fewer traditional Medicare beneficiaries using SNF services in 2020. Average spending per SNF user was $2,724 (16.3 percent) higher in 2020 compared to 2019, driven by an increase in average spending per day (+$44), with an increase in the average length of stay (+1.6 days) also contributing. Additionally, rural Medicare enrollees use the SNF benefit at a rate that is 15 percent higher than the rate for urban enrollees.

SNF-at-home provides opportunities for payers, health systems, and providers to lower costs, facility-associated infections, promote patient compliance, free up capacity in facilities, and address practitioner burnout. SNF-at-Home may not be a fit for every patient, but it is an important option for patients and providers to have, especially for rural patients. An integrated SNF-at-home program can bring services directly to the patient, allowing them to recover in a familiar environment. **MHH understands the Committee is interested in post-acute care, and urges the Committee to discuss a model for SNF-at-Home.**

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In-Home Primary Care

Access to primary care providers (PCPs) in rural areas is significantly hampered. According to the National Rural Health Association, "the patient-to-primary care physician ratio in rural areas of only 39.8 physicians per 100,000 people, compared to 53.3 physicians per 100,000 in urban areas." MHH believes that expanding access to in-home primary care has the potential to increase rural access to routine medical visits. Specifically, MHH recommends creating capitated arrangements to allow primary care providers to better care for patients in the home without the constraints of fee-for-service (FFS) billing and documentation. These visits may happen via telemedicine or telephone check-ins with a physician, or nurse, group, and home visits. Identification and care management of high-risk patients and integration of mental health services may also be considered.

H.R. 2853 would direct the Health and Human Services Secretary to allow PCPs enrolled in Medicare Part B to elect to receive a monthly capitated payment for Primary Care Qualified Evaluation and Management Services (PQEM) as an alternative to FFS reimbursement. **MHH believes that this care model would increase access to primary care in rural areas**, thereby increasing regular health checks and screenings that may help to address poor long-term health outcomes in rural areas.

Home Infusion

Home infusion services can be delivered in rural areas, and with increased access, would help to alleviate the travel burden that many rural patients experience. A recent study showed that 13.1 percent of patients receiving home infusion services lived in rural areas. The study concluded that home infusion use is well-established in rural areas and may increase accessibility to infusion services for rural Americans.

To continue expansion of access to home infusion, the Medicare reimbursement structure must be completed. MHH recommends establishing Medicare Part B coverage of services and supplies associated with the delivery of home infusion. Currently, Medicare Part D covers the cost of most home infused drugs, but excludes the services associated with the delivery of the drugs, including equipment, supplies, and administration. CMS has determined that it does not have the authority to cover infusion-related services, equipment, and supplies under Part D. As a result, rural Medicare beneficiaries may be forced to travel to a hospital or other facility to receive infusion services. **H.R. 2853 would require Medicare Part B to cover the services and supplies associated with the delivery of home infusion, thereby making it more accessible for rural patients.**

Home Dialysis

Approximately 22 percent of those on dialysis live in a rural area and those who live over 100 miles from a dialysis center have higher mortality rates than those who live in closer proximity. Home dialysis offers a potential solution for rural Americans living with end-stage renal disease (ESRD), as they could complete dialysis in the home rather than traveling long distances to receive dialysis multiple times per week. This may also alleviate caregiver burden for those who provide transportation for a loved one on dialysis.

MHH recommends bolstering access to home dialysis by providing Medicare reimbursement for staff assistance for home dialysis treatment. **H.R. 2853 includes the Improving Access to Home Dialysis Act provides a framework for this model.** Specifically, the legislation:

1. Provides for reimbursement through Medicare for in-home assistance by staff of the dialysis facility to patients on home hemodialysis and peritoneal dialysis for the first 90 days of their regimen;
2. Provides for in-home respite staff assistance under certain circumstances outside the initial 90 days;
3. Provides for the possibility of continuous staff assistance without a time limit for patients with certain disabilities;
4. Expands the types of healthcare professionals who can provide home dialysis training;
5. Provides for additional educational opportunities for patients to learn about the entirety of their dialysis options, including opportunities that can be provided in group settings or via telehealth;
6. Provides for training on home dialysis to occur, when possible, in the location the patient intends to use to dialyze.

In-Home Labs

In-home lab testing also can increase access for rural patients who may have limited capacity for travel to a health care facility. Currently, Medicare does not provide ad additional payment for the collection of labs from non-homebound patients or costs of postage and supplies to mail labs. These costs fall on providers or laboratories when services are offered to non-homebound patients. Still, patients in rural areas may benefit from access to in-home labs even though they may not be considered home-bound. MHH recommends that we should ensure receiving preventative and diagnostic labs is as easy as possible for patients in rural areas.

H.R. 2853 would establish reimbursement of an add-on payment to cover travel costs and mail costs associated with specimen collection of in-home lab tests for certain beneficiaries. **MHH recommends that the eligibility for this add-on payment be more comprehensive than the homebound status and take things like barriers to accessing care in rural areas into consideration.**

Advanced Diagnostic Imaging in the Home

MHH also recommends legislation to permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries and require the Secretary of the Department of Health and Human Services to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging.

Currently, there is a Portable X-Ray Benefit in Medicare Part B but it is limited in types of diagnostics reimbursable. However, the Benefit was last updated in 2007. Technologies and capabilities have evolved significantly since then. Now, mobile imaging can provide comprehensive X-Ray, EKG, and ultrasound services quickly, safely, and affordably in the home.

H.R. 2853 provides a model for increased access to advanced diagnostic imaging in the home; it would require HHS to conduct an evaluation of Medicare in-home reimbursable advanced diagnostic imaging. It would permit the delivery and reimbursement of ultrasound imaging in the home for certain beneficiaries, which is currently restricted. Further, the Secretary of HHS would determine the screening tool or utilization management that would trigger beneficiary eligibility.

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Moving Health Home greatly appreciates the House Ways & Means' leadership in working to ensuring patients are able to receive care from their homes, particularly for rural and underserved communities.

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We look forward to working with you to develop and advance bipartisan legislation to enhance care in the home access for Medicare beneficiaries. If you have any questions or would like to hear from Moving Health Home member experts on these topics, please do not hesitate to contact Rikki Cheung at rcheung@movinghealthhome.org.

Sincerely,

Krista Drobac

Krista Drobac
Executive Director
Moving Health Home

OCHIN

A driving force for health equity

Transmitted via electronic mail to WMSubmission@mail.house.gov

March 11, 2024

The Honorable Jason Smith
Chairman
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Ways & Means Committee
U.S. House of Representatives
1011 Longworth House Office Building
Washington, DC 20515

Re: *Statement for the Record – Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities*

Dear Chairman Smith and Ranking Member Neal,

On behalf of OCHIN, we appreciate the opportunity to submit comments for the record in response to the U.S. House of Representatives' Committee on Ways & Means' *Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities*. OCHIN is a national nonprofit health information technology and research network that serves nearly 2,000 community health care sites with 25,000 providers in 40 states, reaching more than 8 million patients including Critical Access Hospitals, rural and frontier health clinics as well as federally qualified health centers and local public health agencies. We strongly support your focus on opportunities and challenges to enhance access to care in patients' homes and modernizing care in rural and underserved communities. In rural communities across the nation, the infrastructure, workforce, and sustainable funding needed to keep the doors open among Critical Access Hospitals and community clinics simply do not exist. In a recent analysis, half of rural hospitals could not cover their costs, up from 43% the previous year and 418 rural hospitals across the U.S. are "vulnerable to closure."[1] Innovative and fundamental investments are needed to revive rural America—communities that serve as the bedrock of America's independence and self-sufficiency.

OCHIN: DRIVING INNOVATION, ACCESS, AND SELF-SUFFICIENCY

For over two decades, OCHIN has advanced health care solutions by leveraging the strength of our network's unique data set and the practical experience of our members to drive technology innovation for patients and providers in rural and other underserved communities. OCHIN offers technology solutions, informatics, evidence-based research, and workforce development and training in addition to policy insights. OCHIN has the largest collection of community health data in the country and more than two decades of practice-based research and solutions expertise. We provide the clinical insights and tailored technologies needed to expand patient access and connect care teams, and improve the health of rural and medically underserved communities. With over 137 million clinical records exchanged last year, OCHIN puts "one patient, one record" at the heart of everything we do to connect and transform care delivery. We ensure all health records flow seamlessly between patients and their many providers, giving clinicians greater insight into their patients' health and helping to complete the circle of care in

[1] Operating in the Red: Half of Rural Hospitals Lose Money, as Many Cut Services, KPP Health News (March 7, 2024) (Accessed March 8, 2024).

rural communities. We also drive interoperability on a national scale through our growing health information network and automated electronic case reporting for public health. In addition, OCHIN maintains a broadband consortium network to support rural health care providers access Federal Communications Commission (FCC) subsidies.

THE CHALLENGE: PERSISTENT HISTORICAL DISPARITIES COMPOUNDED BY DIGITAL DIVIDE

Rural communities face unique and formidable challenges that threaten their resiliency and sustainability. Across the nation, rural providers have crumbling infrastructure, inadequate payment models, endemic staffing and clinician shortages, lack of broadband hampered by bureaucratic and overly complex subsidy programs, and patients who must drive long-distances to access care (when they do have transportation and sufficient time). Addressing worsening health outcomes in Rural America and building vibrant rural communities go together. Rural providers that can sustainably provide health care in prosperous and challenging times alike remain the backbone of rural communities as a significant employer. And just as healthcare providers play a central role in rural communities, the vitality of our nation is dependent on a thriving Rural America.

Rural providers must manage:

- Higher Disease Burden and Health Disparities. Patients in rural communities are older and have a higher prevalence of chronic disease, such as heart disease, diabetes, and obesity than their urban counterparts. Rural Americans are more likely to die from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts. Shortages of mental health and behavioral health clinicians in rural communities have amplified the deadly consequences of the mental health crisis. Farmers are 3.5 times more likely to die by suicide than the general population.[2] Social determinants of health, such as poverty, limited access to transportation, and inadequate housing, contribute to health disparities among rural seniors. The Centers for Disease Control and Prevention (CDC) notes that rural seniors are more likely to experience food insecurity and social isolation, which can negatively impact their health and well-being.
- Higher Per Patient Costs and Risk. Rural providers shoulder higher per patient costs due to the lower volume of patients served yet payment policies do not reflect this basic financial reality. Rural hospitals need volume to lower their marginal cost to improve sustainability. Covering existing costs without a margin and at a loss prevents them from modernizing infrastructure (including health IT), investing in workforce development, cybersecurity, and digital health innovations including AI. Further, with the focus on value-based payment (VBP), identifying high-risk patients and implementing population health management strategies are essential for success in such models. Yet, rural providers have smaller patient populations, making it challenging to achieve meaningful risk stratification and develop targeted interventions for improving outcomes and reducing costs.
- Endemic Clinical and Operational Staff Shortages. While clinician shortages are prevalent across the nation, rural communities face more persistent and deepening shortages of primary care, specialty services, and emergency care due to geographical isolation. HRSA reports over 65 million Americas live in primary care Health Professional Shortage Areas (HPSAs), with a majority located in rural areas. Clinician shortages only tell half of the story. Rural communities also face

[2] Farmers 3.5 times more likely to die by suicide, National Rural Health Association says, 10News, February 23, 2024 (Accessed 3/11/24)

shortages of health IT professionals including those needed to strengthen cybersecurity. As the unfilled jobs gap widens, the onus has been placed on other non-health IT staff to acquire an increasing array of IT skills and competencies.

- Inaccessible Health IT Workforce Training and Development Programs and Technical Assistance. Existing federal and state programs do not provide rural providers ready access to funding for health IT upskilling programs and community-based training initiatives that provide ready on-ramps to careers for individuals without college degrees. Further, rural providers do not receive resources to hire technical staff nor access technical assistance that would ensure they can optimize digital health technologies. Existing workforce development programs do not reflect the health IT needs of rural communities. And rural providers do not have the resources and technical expertise to collect, analyze, and report the necessary data for VBP initiatives nor resources to implement essential cybersecurity measures and training. Addressing workforce training needs including promoting digital literacy among healthcare professionals and operational staff is essential to transform health care delivery and ensure cyber hygiene.
- Antiquated Health IT System and Aged Infrastructure and Buildings Requiring Basic Yet Costly Maintenance and Replacement. Adoption rates of upgraded and modernized electronic health records (EHRs) in rural healthcare facilities are lower due to cost barriers, technical limitations, and workforce capacity constraints. Integrating EHR systems with existing workflows and ensuring interoperability with other healthcare systems is costly and complex, particularly for small, rural providers and they have not received funding or resources to implement such updates, in over a decade. Interoperability challenges and fragmented health information systems impede the exchange of patient data between healthcare providers, hospitals, and clinics in rural areas. This lack of seamless data sharing leads to gaps in care coordination, redundant tests, and inefficiencies in healthcare delivery. Because of systemic underfunding of rural communities, rural providers are not able to maintain buildings and infrastructure nor retrofit or replace essential infrastructure creating conditions that undermine the delivery of care, and in some cases compromising safety and impeding efforts to recruit and retain staff.
- Limited Broadband Access and Arcane, Punitive, and Complex Subsidy Programs. Rural areas often lack access to high-speed internet infrastructure, which is essential for health information exchange, EHR, and a host of virtual services including telehealth, eConsults, and remote physiological monitoring. Without reliable connectivity, rural healthcare providers cannot deliver a range of virtual services and access online resources. The Existing FCC program for rural health care providers requires specialized expertise, is complex, legalistic and resource intensive with loss of funding for failing to meet exacting, voluminous and duplicative documentation requirements. The providers that need it the most lack the resources (staff) to provide the volumes of documentation and information required by the FCC.
- Restrictive and Uncertain Telehealth/Virtual Services Regulatory and Payment Policies. The changing sands of Medicare reimbursement, potential reduction in reimbursement due to AMA's CPT Editorial Panel telehealth coding changes,[3] and varied state Medicaid, managed care and commercial health insurer payment policies creates confusion, complexity, administrative burden and financial barriers for rural healthcare providers. It also creates significant risk where

[3] There is concern that recent changes to CPT coding for telehealth changes will result in lower payment for virtual services even though the cost of such services is equal to the cost for in-person. (This will also overnight nullify state parity laws by creating parallel, but different codes for the delivery of the same service but using a different delivery mode.) In the OCHIN network patients who lack transportation or do not have stable housing are more likely to use telehealth options. Lower reimbursement for telehealth will disproportionately impact providers in rural and underserved communities.

continuous changes heighten compliance challenges. There is an unprecedented level of evidence demonstrating the value of virtual services to patients and providers in rural and other underserved areas. Yet, Medicare and other payers continue to add new restrictions and documentation requirements. And the regulatory environment also continues to change (licensure and controlled substance prescribing). This comes at a time of shortages and record rates of clinician and operational staff burn-out. This drives complexity and cost which ultimately closes the door for rural patients and providers.

- Skyrocketing Cybersecurity Risks and Threats and Inadequate Resources to Implement New AI Systems. Rural healthcare facilities have limited resources to invest in essential cybersecurity measures and infrastructure upgrades, making them vulnerable to cyberattacks and data breaches. Protecting patient privacy and securing digital health systems against cyber threats requires foundational investments that have not been made in Rural America. And as the race to innovate in health care is fueled by AI breakthroughs among flagship health systems and large technology companies, rural and underserved providers and communities will only be left further behind without the necessary infrastructure, staffing, and essential guardrails needed to implement and innovate in this space. All of this requires significant investments targeted to onboard rural and underserved providers.

RECOMMENDATIONS

Many of the challenges outlined above require strategic and targeted funding and programmatic streamlining of existing federal programs to remedy. The solutions are interrelated and involve investments in people as well as technology in addition to traditional brick and mortar. We outline several recommendations below that are an important starting point:

- Modernized Health IT Systems. Rural providers, particularly Critical Access Hospitals, require funding to adopt new fully integrated, right sized systems that can meet their patient population needs and optimize their financial sustainability. Currently, rural providers utilize dated, fragmented technologies. Alternatively, they are dependent on incentives that compel them to use large systems' health IT systems that do not meet rural patient clinical needs nor their operational/financial needs. In these arrangements, the needs of rural providers are secondary to the priorities of large health systems. Congress can leverage existing programs by directing federal agencies such as the USDA to streamline and simplify its community grants program as this could be used to fund adoption of modernized health IT. Currently, the arcane requirements of this program prevent rural providers, who do not have grant writers, from applying to these programs. Further, Congress could direct some of the previously authorized and appropriated broadband funding to include modernized health IT systems and cybersecurity as these are prerequisites to closing the digital divide.
- Virtual Specialty Services Network Dedicated to Patients in Rural and Underserved Communities Integrated with Primary Care Providers. VBP models require enhanced care coordination and integration across healthcare settings, including primary care, specialty care, and post-acute care. Rural healthcare systems face challenges in developing and maintaining care networks, collaborating with external providers, and ensuring seamless transitions of care for patients. We urge Congress to invest in a demonstration to test a virtual specialty services network that integrates and coordinates with rural primary care providers and specialists, so patients get care when and where they need it. For those rural hospitals or clinics that want to hire specialists to participate in the virtual specialty network, it will enable these rural providers to expand their geographical reach and increase their patient volume—thereby increasing sustainability and access. As discussed below in greater detail, we urge the Committee to support the passage of H.R. 7149, Equal Access to Specialty Care Every Act

of 2024 (EASE Act). The EASE Act would require the Centers for Medicare and Medicaid Services (CMS) Innovation Center to test a delivery model designed to improve access to specialty health services. The demonstration would fund the development of a panel of specialists using virtual modalities targeted to rural primary care providers and those in other underserved areas for their patients who are covered under Medicare, Medicaid, and self-pay (sliding scale). It would include health IT integration with primary care providers and the specialist network.

- Parity for Telehealth Services (Audio-Only and Interactive Video) While Extending the COVID-19 Public Health Emergency (PHE) Regulatory and Payment Flexibilities. The evidence-base produced by the COVID-19 PHE flexibilities—both regulatory and payment—has been substantial and represents real world evidence generated from different sites of care, regions, health conditions, and patient populations at a scale rarely (if ever) provided in the testing of clinical interventions and modalities. In the OCHIN network, the data has established that these flexibilities have not increased inappropriate utilization, but instead have expanded access to care in lower cost sites of care (ambulatory settings) and have afforded patients facing structural barriers such as lack of transportation and housing insecurity access to care. In addition, OCHIN has tested the use of eConsults to reduce lengthy wait times for specialty care (dermatology) in a frontier community and found that it resulted in cost savings and reduced wait times for those patients that required in-person care. Rural health clinics and Critical Access Hospitals should receive the maximum level of flexibilities to use virtual modalities and the payment must reflect the higher per person cost reality of care delivery in rural communities.
- Invest in Health IT (including Cybersecurity) Workforce Development and Training programs for Rural Communities. The ongoing and deepening shortage of health IT professionals illustrates the need for improved health IT workforce development and training of all health staff—not just staff in the IT department—particularly as the role of technology in care delivery expands. We recommend that Congress streamline existing workforce programs (developed for the 20th Century) and implement new ones that provide a direct on-ramp for individuals with high school diplomas or GEDs in rural communities as part of career ladders. Such programs should include training individuals from rural and underserved communities in partnership with community health clinics, local public health agencies, and Critical Access Hospitals as bridges and ladders to additional opportunities in health care and/or technology. The pathways should include entry points as community health workers or medical biller/coders to data and clinical quality analysts or health information management specialist to and beyond. We urge Congress to invest in online learning options that are coupled to placement opportunities with local rural health care providers to optimize care delivery, establish local career opportunities, and strengthen rural communities.

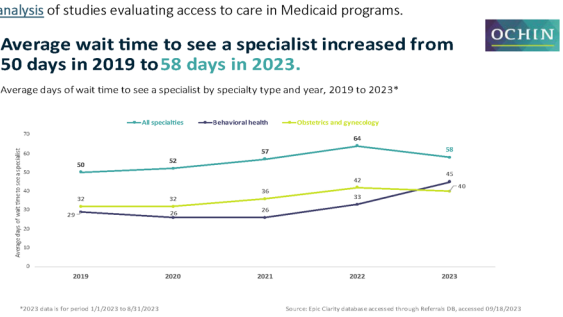
CROSS-CUTTING SOLUTION – SPECIALTY CARE ACCESS AND SUSTAINABILITY

We recommend that the Committee advance a multi-prong set of recommendations while also urging immediate passage of key legislation, the EASE Act, to test a solution that could address several of the outlined challenges. The EASE Act of 2024 would provide funding for a demonstration to build and evaluate a virtual network of specialty providers dedicated to serving patients in rural and underserved communities covered under Medicaid or Medicare to facilitate transitions to value-based care. This bill would not only test a method to expand access to essential specialty care services to patients but would test if such a model could serve as an on ramp for interested rural hospitals and other rural providers to increase volume for their specialists to drive financial sustainability as part of the dedicated specialty panel.

Lack of access to integrated specialty care for patients who live in rural and other underserved communities is a persistent challenge that will only deepen due to endemic clinician shortages and

demographic trends driving increased clinical need. Patients and primary care providers in rural communities need ready access to specialists to address chronic conditions like diabetes, heart disease, and mental health conditions. Left untreated, chronic conditions drive higher disease burden and costs to the health system while worsening health disparities.

OCHIN network data reflects local, regional, and national trends of limited access and lengthy wait times for specialty care, which drives health disparities in rural and other underserved communities. This reality was documented in the OCHIN network before the COVID-19 PHE and similar trends have continued despite the availability of extensive telehealth flexibilities during the COVID-19 PHE. The overall average wait time to see a specialist has increased to 58 days in 2023 from 50 days in 2019. The average wait time to see certain specialists is even more pronounced: neurologists (84 days), gastroenterologists (71 days), and ophthalmologists (66 days). Medicaid insurance is associated with a 3.3-fold lower likelihood in successfully scheduling a specialty appointment when compared with private insurance as found in a meta-analysis of studies evaluating access to care in Medicaid programs.



OCHIN conducted a specialty demonstration to pair a rural provider with a dermatologist utilizing eConsults. The findings were clear that using virtual modalities drives access, improves the quality of care, and increases savings. This modality saved 59% of what would have otherwise been referrals to a dermatologist. Average time to care was reduced from 55 days to 10 days. Further, for patients who needed an in-person appointment with a dermatologist, they were prioritized based on need, and were typically seen more quickly than standard referrals.

Specialist shortages, geographic mismatches, lack of transportation, other structural impediments, and non-competitive Medicaid reimbursement rates compared to Medicare and commercial health insurers contribute to these delays. However, two powerful factors include the lack of: (1) specialist networks with requisite licensure and ready willingness to accept referrals from providers in rural and underserved communities; and (2) streamlined technological connections and technical assistance to support operational needs and coordination for specialists and primary care providers in rural and underserved communities.

It is critical to conduct the demonstration among providers with the most challenging mix of patients to ensure provider sustainability in rural and underserved communities. This model should be tested among providers that serve a significant number of Medicaid insured and under- and uninsured patients (who self-pay including on a sliding scale) along with those with Medicare coverage. In rural and underserved communities there are fewer Medicare and commercially insured patients relative to providers serving patients in more affluent communities.

While the recent CMMI Making Care Primary Model (MCP) demonstration contains many essential provisions to support sustainable transitions to value based payment, a key component that will undermine participant success remains the lack of dedicated specialty care clinician networks. The MCP model (which is limited to 8 states) provides a nod to specialty care access by providing a payment mechanism for services but does not address the lack of access that primary care providers and their patients have to clinician specialty networks that will accept the patient mix they serve. Such virtual specialty clinician networks do not exist.

The EASE Act demonstration would fund the technological infrastructure, technical assistance, and the creation of a dedicated virtual network of specialty clinicians that accept referrals from safety net providers. The virtual specialty network would utilize a range of virtual modalities (including clinical decision support, eConsults, and telehealth, for example) and coordinate care with primary care clinicians. The demonstration would test the impact on access, health outcomes, and the role of timely specialty care access that is coordinated with primary care on costs while also providing an assessment of the impact on sustainable transition to value-based payment for providers in rural and underserved communities.

CONCLUSION

Passage of the EASE Act along with the permanent extension of COVID-19 PHE telehealth regulatory and payment flexibilities along with improved parity of coverage of other virtual modalities in the Medicare and Medicaid programs for rural health clinics is a critical first start. Congress also can ensure already authorized and appropriated funding is used as ultimately intended—overcoming the digital divide faced by rural communities.

Thank you for your leadership. Please contact me at stollj@ochin.org if you would like additional data and information.

Sincerely,

Jennifer Stoll
Chief External Affairs Officer

HEALTHCARE
LEADERSHIP COUNCIL

March 19, 2024

The Honorable Jason Smith
Chair
House Ways and Means Committee
Washington, D.C. 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
Washington, D.C. 20515

Dear Chair Smith and Ranking Member Neal:

On behalf of the Healthcare Leadership Council (HLC), we thank you for holding a hearing "Enhancing Access to Care at Home in Rural and Underserved Communities." Improving access though telehealth flexibilities and the delivery of acute care in the home not only provide important access vehicles for particular communities, but these methods can also mitigate ongoing workforce and caregiver challenges that remain top of mind to the members of HLC.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, homecare providers, group purchasing organizations, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

Improving Access with Telehealth

Over the past several years the value of telehealth in healthcare delivery has emerged as paramount, especially for vulnerable populations. HLC commends Congress for extending telehealth waivers through the end of 2024 and recommends building upon this critical foundation by removing the existing prohibitions under Section 1834(m) of the Social Security Act which prevent patients from receiving telehealth services where they are located. Limiting telehealth services to originating sites reduces patients' ability to receive important care in a setting they prefer. Telehealth flexibilities and other care delivery options mitigate the infrastructure challenges many rural and underserved communities face and ensure patients are not left behind in accessing future care innovations. Given these additional modes of care delivery, we encourage the Committee to make certain that patients are not unduly burdened by additional hurdles to receive telehealth.

Improving Access with Care at Home

Beyond the flexibilities of telehealth, opportunities to deliver care at home are also critical for improving access and health as the hearing's focus reflects. We commend Congress for extending the Acute Hospital Care at Home waiver program that allows patients to receive acute care in the home. These tools have enabled the delivery of high quality and lower cost care where the patient resides. We encourage Congress to make this care at home waiver and the telehealth waiver permanent.

Mitigating Healthcare Workforce Challenges

As Congress further explores facilitating access through telehealth and the delivery of care at home, consider the relief these innovations and associated waivers provide given continued workforce shortages in healthcare particularly. The direct care workforce comprises about 4.5 million workers (including nearly 2.3 million home care workers), over 700,000 workers in residential care homes, about 580,000 nursing assistants employed in nursing homes, and nearly 900,000 workers employed in other settings, such as hospitals.[1] This workforce is the backbone of services and supports in healthcare delivery. These professional caregivers play a critical role in supporting the lives of people who have functional limitations because of age or disability. The physical, emotional, and financial challenges direct care workers face cannot be overstated, and, for many, the challenges have increased in recent years.

Mitigating Caregiver Workforce Challenges

There is also a significant economic impact for family caregivers who provide about $600 billion annually in unpaid care to their loved ones. These caregivers face out-of-pocket expenses to assist their family members, as well as foregone potential income and retirement savings. An AARP report found that family caregivers spent 36 billion hours caring for adults with chronic, disabling, or serious health conditions with an estimated economic value of $600 billion in 2021.[2]

Despite the loss of personal income, these family caregivers not only provide important support to loved ones but also save taxpayer dollars by delaying or preventing more costly nursing home care and unnecessary hospital stays. Therefore, HLC urges Congress to pass H.R. 7165/S. 3702, the "Credit for Caring Act" which would create a new, nonrefundable federal tax credit of up to $5,000 for eligible working family caregivers to help address the financial challenges of caregiving. Eligible working individuals providing care for family members of all ages could receive the credit if the care recipient meets certain functional or cognitive limitations or other requirements.

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[1] Placing a Higher Value on Direct Care Workers, The Commonwealth Fund (2021) Placing a Higher Value on Direct Care Workers | Commonwealth Fund

[2] AARP: Valuing the Invaluable: 2023 Update Strengthening Supports for Family Caregivers (March 8, 2023) Valuing the Invaluable 2021 Update Strengthening Supports for Family Caregivers - AARP Insight on the Issues

This tax credit would help family caregivers who care for non-dependents or who do not live with the person they are assisting.

Mitigate Community-funded Workforce Challenges

In addition, HLC urges Congress to pass H.R. 547/S. 100, the "Better Care Better Jobs Act." The bill would strengthen and expand the home and community-based services (HCBS) workforce. The bill enhances Medicaid funding for HCBS through increasing the Federal Medical Assistance Percentage (FMAP) by 10 percent permanently for states that expand access to HCBS and strengthen the HCBS workforce. To receive the enhanced FMAP, states would need to: promote access and improve workforce recruitment and retention; review HCBS payment rates every two years with input from stakeholders; ensure increases in HCBS rates are passed through to workers to improve compensation; confirm that rates are incorporated into managed care arrangements; and update, develop, and adopt qualification standards and training opportunities for workers and family caregivers.

HLC looks forward to continuing to collaborate with you on these important access and workforce challenges and consider opportunities to more efficently and effectively deliver care to patients. If you have any questions, please do not hesitate to contact me at kmahoney@hlc.org or (202) 449-3442.

Sincerely,

Katie Mahoney,
Executive Vice President and Chief Policy Officer

Hackensack
Meridian *Health*

Via email submission to WMSubmission@mail.house.gov
The Honorable Jason Smith
Chairman, U.S. House Committee on Ways and Means
1139 Longworth HOB
Washington D.C. 20515

March 25, 2024

Re: Comments on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Chairman Smith:

On behalf of Hackensack Meridian *Health* (HMH), we thank you for holding a hearing on "Enhancing Access to Care at Home in Rural and Underserved Communities" and appreciate the opportunity to submit comments on this subject.

HMH is the largest, most comprehensive, and truly integrated healthcare network in New Jersey, comprising a network of hospitals that includes three academic medical centers, one university teaching hospital, two children's hospitals, nine community hospitals, a behavioral health hospital, two rehabilitation hospitals, and one long-term acute care hospital. Six of our 18 hospitals maintain robust academic medical programs. HMH also has more than 500 patient care locations, including ambulatory care centers, surgery centers, home health services, long-term care and assisted living communities, ambulance services, lifesaving air medical transportation, fitness and wellness centers, rehabilitation centers, urgent care centers, and physician practice locations. HMH has more than 36,000 team members and more than 7,000 physicians within its network and is a distinguished leader in healthcare philanthropy, committed to the health and well-being of the communities it serves.

Background

During the COVID-19 Public Health Emergency ("COVID-19 PHE" or "pandemic"), the Centers for Medicare & Medicaid Services (CMS) waived several requirements for the duration of the public health emergency (PHE) under a blanket waiver after it was granted temporary authority by the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. These included telehealth geographic and originating site requirements, prohibitions against reimbursing for telehealth at the same rates as in-person care, and enabling hospitals to care for acute patients in their homes under the Acute Hospital Care at Home waiver.

On March 3, 2020, HMH's Hackensack University Medical Center admitted the first patient to test positive for COVID-19 in New Jersey. Since then, our network treated over 250k patients with COVID and administered 875,000 vaccine doses These waivers enabled HMH

to continue to provide patient care while preventing the spread of COVID-19, as well as rapidly expand capacity to address surges in COVID-19 cases.

Today, about four years later, these waivers have allowed hospital systems like HMH to innovate to improve access, reduce costs, and improve the quality of healthcare that we deliver to our communities. The Consolidated Appropriations Act of 2023 (CAA) authorized an extension of the telehealth and hospital-at-home flexibilities through the end of 2024. We ask that Congress take action before the end of this year to further extend and ultimately make these flexibilities permanent.

Telehealth

During COVID pandemic surges, telehealth flexibilities - including geographic and originating site requirements - enabled HMH to continue to provide patient care while preventing the spread of the virus, as well as rapidly expand capacity to address surges in COVID-19 cases. Embracing these policies throughout the pandemic and beyond has changed the way HMH operates and has led to innovations in care delivery that have allowed us to become more patient-centered, make better use of existing technology, and reduce barriers to accessing care. A permanent change to the underlying statute would ensure providers can continue to leverage the care delivery gains that have been made and provide certainty to encourage future innovation.

Payment Parity

Paying for care delivered via telehealth at parity with in-person care enables ongoing investment in telehealth infrastructure, which has increased access to care for many beneficiaries. Telehealth utilization at HMH has expanded as a result and is especially important for individuals who face barriers to accessing medical care due to a variety of factors, including for example, transportation limitations, an inability to take time off from work, lack of child care, or for people with disabilities. Prior to the pandemic, about four percent (4%) of ambulatory care visits were conducted via telehealth across the HMH network. Today, around 8-10 percent (8-10%) of ambulatory care visits are conducted via telehealth, and increasing steadily as patients and providers grow more accustomed to telehealthcare.

While Congress considers whether Medicare reimbursement rates for telehealth should be reduced compared to in-person care, we ask that you consider the following factors.

Providers who treat patients in person and offer telehealth as part of their mix of services to ease access for patients still have the same overhead costs no matter how the care is delivered. HMH has taken steps to ensure that most of its 7,000 physicians offer patients telehealth appointments to improve access to care for patients who cannot access specialty providers near their homes, have limited transportation options, are disabled, or cannot leave work to see the doctor. However, many of these same physicians report that offering telehealth is disruptive to their practices, requiring frequent reschedules when the provider's day is running late, requiring a dedicated room in their office for telehealth appointments to

maintain patients' privacy, and requiring the purchase and maintenance of telehealth-capable technology. Providing telehealth visits as part of their normal office day, while providing a significant benefit to the patient, does not reduce administrative and overhead costs, such as staff, rent, insurance, or other overhead costs. If Congress were to reduce reimbursement rates for care offered via telehealth, we believe that many providers would stop offering it to their patients.

Moreover, the use of telehealth is most prominent in behavioral healthcare, where there is an acute shortage of providers and a tsunami of demand. According to the New Jersey Association of Mental Health and Addiction Agencies, New Jersey has a 31.4 percent vacancy rate for clinical staff at mental health agencies across the state.[1] Psychiatrists and psychiatric subspecialists, like child psychiatrists, often do not accept managed care, Medicaid, and Medicare due to already low reimbursement rates.[2] More than 60 percent (60%) of HMH behavioral health patient visits are provided via telehealth in order to increase the number of patients that our providers can treat each day and to extend their service area to the entire state, including rural and underserved communities. If telehealth visits were reimbursed at rates less than in-person care, we believe that more providers would stop providing telehealth or would be more likely to drop out of Medicare and Medicaid.

Recommendation: Preserve payment parity for telehealth.

Reform the Tele-mental Health In Person Visit Requirement
The extension of telehealth flexibilities provided in the CAA of 2023 delayed the requirement that beneficiaries must receive an in-person visit within 6 months of an initial assessment and every 12 months thereafter to receive tele-mental health care. HMH is grateful for this extension and recommends that Congress make it permanent.

The policy of requiring periodic in-person visits for mental health care does have some clinical validity. For example, many mental health medications require an assessment of a patient's height and weight for proper dosing. Additionally, there are certain physical conditions that can present as mental health disorders, so an in-person exam and lab tests would be necessary to rule out these conditions. However, the national shortage of mental health professionals makes it likely that most New Jerseyans, particularly in rural and medically underserved communities, do not have access to a psychiatrist or other specialized mental health care provider located in their communities. HMH, therefore, believes a more innovative approach would be requiring periodic in-person visits with a lower-cost primary care provider instead of in-person visits with their behavioral health provider.

HMH is also concerned that the qualifying in-person visit may be interpreted too narrowly to allow patients to benefit when they receive or are referred to behavioral health services from

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[1] https://www.njamha.org/links/VacancySurveyResultsNov2022.pdf
[2] https://www.nami.org/Support-Education/Publications-Reports/Public-Policy-Reports/Out-of-Network-Out-of-Pocket-Out-of-Options-The/Mental_Health_Parity2016.pdf

other care settings. Patients should be able to enter the behavioral health system through a visit with their primary care provider (PCP) or following a crisis that requires treatment at an emergency department (ED) or behavioral health urgent care. Requiring patients seeking behavioral health treatment to have another in-person visit when the PCP or ED can do the diagnosis and assessment is burdensome, inefficient, and contributes to a lack of parity between behavioral and physical health care.

Recommendation: Permanently eliminate the requirement that beneficiaries must receive an in-person visit within 6 months of an initial assessment and every 12 months thereafter to receive telemental health care OR revise the requirement to allow in-person visits with a lower-cost primary care provider instead of an in-person visit with a behavioral health provider.

Acute Hospital Care At Home

As part of the flexibilities provided by CMS in March 2020, CMS waived hospital conditions of participation which require nursing services to be provided on premises 24 hours a day, 7 days a week and the immediate availability of a registered nurse for care of any patient. This Acute Hospital Care At Home ("AHCAH" or "H@H") waiver enabled hospitals to apply for an individual waiver to provide certain acute care to patients in their homes, providing much-needed flexibility for hospitals to decant their inpatient and medical-surgical floors and limit the spread of disease. Congress extended these flexibilities through the end of 2024.

As of March 22, 2024, 320 hospitals in 37 states participate in the AHCAH program. Three of HMH's hospitals, Hackensack University Medical Center (Hackensack), JFK University Medical Center (Edison), and Jersey Shore University Medical Center (Neptune) participate under the waiver. While HMH is grateful that CMS took steps to support hospitals in managing patient needs during the COVID-19 PHE, we believe that there are many benefits to permanently continuing the hospital-at-home care model.

Studies have shown that when compared with traditional patients, H@H patients have lower rates of readmissions[3] and skilled nursing facility admissions.[4] Hospital care at home has also been shown to be a safe and effective alternative to institutional or hospital care.[5] HMH believes the model has the potential to improve care, especially in underserved communities, and could offer significant savings to Medicare relative to the cost of hospital facility construction and maintenance. Continuing to offer and extend flexibilities to furnish care in patients' homes will provide patients with increased agency over their care and yield savings to Medicare while maintaining or improving quality.

HMH has begun to evaluate the impact of expanded Hospital at Home care in our facility planning over the next ten years. If this program is made permanent, we believe that we

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[3] Source: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2780783

[4] https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2685092

[5] https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0338;
https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.17759?af=R

can confidently reduce the number of hospital beds that are necessary to meet patient care demands in our communities, thereby saving capital construction costs for the healthcare system.

While HMH is providing hospital at home through three sites, we have hesitated to invest in this program more expansively until Congress signals that the program will not be withdrawn. We ask that Congress provide a minimal five-year extension to the current Acute Hospital Care At Home program to provide certainty, allowing the industry to confidently invest in growing this service while providing much-needed patient encounters that will allow CMS to study and recommend revisions to how the program operates.

Recommendation: Enact a minimal five-year extension to the current Acute Hospital Care At Home program.

Conclusion

Thank you for the opportunity to comment on Enhancing Access to Care at Home in Rural and Underserved Communities. We would be pleased to discuss any of the above in greater detail at any time. If you have questions, please feel free to contact me at Sarah.Lechner@hmhn.org.

Sincerely,

Sarah Lechner
Senior Vice President and Chief of External Affairs

Mass General Brigham

399 Revolution Drive
Somerville, MA 02145

March 15, 2022

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
1130 Longworth House Office Building
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1129 Longworth House Office Building
Washington, DC 20515

Submitted via WMSubmission@mail.house.gov

Dear Chairman Smith and Ranking Member Neal:

On behalf of Mass General Brigham, we are grateful for the opportunity to provide written comments for the March 12th hearing by the House Committee on Ways and Means on "Enhancing Access to Care at Home in Rural and Underserved Communities." Medicare plays a key role in expanding access to and supporting innovation in home-based care across the country. In particular, the Medicare Acute Hospital Care at Home (AHCAH) program has enabled over 300 hospitals across 37 states to provide hospital-level care at home.[1] Research suggests that the AHCAH program provides safe and quality care that is patient centered and equitable.[2] Therefore, ***we urge the Committee to advance legislation to extend by at least 5 years the Medicare Acute Hospital Care at Home (AHCAH) program before it expires on December 31, 2024.***

Mass General Brigham is a not-for-profit healthcare system committed to patient care, research, teaching and service to both the local and global community. The Mass General Brigham network includes five Harvard-affiliated teaching hospitals: Massachusetts General Hospital, Brigham and Women's Hospital, Mass Eye and Ear, Spaulding Rehabilitation Hospital and McLean Hospital along with multiple community health centers and hospitals, a physician network, home health, and long-term care services and a health insurance plan. We are the largest private employer in Massachusetts, with approximately 80,000 employees, including physicians, nurses, scientists, and caregivers.

Since 2016 Mass General Brigham's Home Hospital program, referred to throughout as '**H**ome **H**ospital,' has been caring for patients, making it one of the largest and most experienced programs in the country. The Home Hospital program operates at five of our hospitals - Brigham and Women's Hospital, Massachusetts General Hospital, Newton-Wellesley Hospital, Salem Hospital, and Brigham and Women's Faulkner Hospital. The program has a 40-bed capacity and has served over 5,000 patients. It has shifted the site of care for over 15,000 patient days that would have otherwise been spent inside a traditional hospital. Our Home Hospital patients reflect the diversity of our community - 20 percent are non-English speaking, 37 percent are non-White, and 19 percent are Hispanic.

The Mass General Brigham Home Hospital program provides a home-based alternative to a facility-based inpatient hospital stay by maximizing care and recovery time within the comfort of a patient's home.[3]

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[1] https://qualitynet.cms.gov/acute-hospital-care-at-home/resources
[2] Levine DM, Souza J, Schnipper JL, Tsai TC, Leff B, Landon BE. Acute Hospital Care at Home in the United States: The Early National Experience. Ann Intern Med. 2024 Jan;177(1):109-110. doi: 10.7326/M23-2264.
Adams D, Wolfe AJ, Warren J, Laberge A, Richards AC, Herzer K, Fleisher LA. Initial Findings From an Acute Hospital Care at Home Waiver Initiative. JAMA Health Forum. 2023 Nov 3;4(11):e233667. doi: 10.1001/jamahealthforum.2023.3667.
[3] https://www.massgeneralbrigham.org/en/patient-care/services-and-specialties/healthcare-at-home/home-hospital#benefits

for-service Part A claims filed between July 2022 and June 2023. Fifty-four percent of the patients were female, 85.2 percent were white, 61.8 percent were over 75 years old, and 18.1 percent were disabled. When the team studied hospitalizations among all these patients, they found a 0.5 percent mortality rate and 6.2 percent escalation rate (returning to the hospital for at least 24 hours). In addition, within 30 days of discharge, 2.6 percent of patients used a skilled nursing facility, 3.2 percent died, and 15.6 percent were readmitted. The patients included in the current study had medically complex conditions, including 42.5 percent with heart failure, 43.3 percent with chronic obstructive pulmonary disease, 22.1 percent with cancer, and 16.1 percent with dementia. The five most common discharge diagnoses were heart failure, respiratory infection (including COVID), sepsis, kidney/urinary tract infections, and cellulitis.

A recent study by Medicare researchers found similar results.[7] Patients who received care under the AHCAH program had a low mortality rate and minimal complications related to escalations back to a traditional hospital. This study looked at 11,159 patients who were admitted under the AHCAH program November 2021, through March 2023, including 8,417 with Medicare fee-for-service insurance, 1,705 with non-managed care Medicaid insurance and 1,011 with both. The most common conditions treated, based on the primary diagnosis, were respiratory infections, heart failure and shock, and severe sepsis or septicemia, all with a major complication and comorbidity. For Medicare patients, the median length of stay obtained from claims was five days. The overall proportion of patients transferred from home back to the hospital was 7.20 percent.

In addition to quality and safety, home hospital programs have the potential to reduce overall health care spending by reducing readmissions and less utilization of skilled nursing care.[8,9] The first and only randomized clinical trial study conducted on a home hospital program was conducted by Levine and his colleagues. They found that patients who received care at home had a 38 percent lower total cost of care than control patients.[10] Each patient had been admitted via the emergency department at Brigham and Women's Hospital or Brigham and Women's Faulkner Hospital with a select acute condition — including infection, heart failure exacerbation, chronic obstructive pulmonary disease exacerbation and asthma exacerbation. Patients were randomized to either stay at the hospital and receive traditional hospital care or receive care hospital-level care at home. The team measured the total direct cost of care, including costs for nonphysician labor, supplies, medications, and diagnostic tests. Home hospital patients had fewer lab orders, used less imaging, and had fewer consultations. The team also found that home hospital patients spent a smaller portion of their day sedentary or lying down and had lower readmission rates within 30 days than control patients in a traditional hospital-based setting.

Home hospital programs may also provide insight to providing more equitable care. A recent study showed that patients with disabilities, with dual-eligibility for Medicare and Medicaid, and from historically

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[7] Adams D, Wolfe AJ, Warren J, Laberge A, Richards AC, Herzer K, Fleisher LA. Initial Findings From an Acute Hospital Care at Home Waiver Initiative. JAMA Health Forum. 2023 Nov 3;4(11):e233667. doi: 10.1001/jamahealthforum.2023.3667.

[8] Edgar K, Iliffe S, Doll HA, Clarke MJ, Gonçalves-Bradley DC, Wong E, Shepperd S. Admission avoidance hospital at home. Cochrane Database of Systematic Reviews 2024, Issue 3. Art. No.: CD007491. DOI: 10.1002/14651858.CD007491.pub3.
Caplan GA, Sulaiman NS, Mangin DA, Aimonino Ricauda N, Wilson AD, Barclay L. A meta-analysis of "hospital in the home". Med J Aust. 2012 Nov 5;197(9):512-9. doi: 10.5694/mja12.10480.

[9] Federman AD, Soones T, DeCherrie LV, Leff B, Siu AL. Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences. JAMA Intern Med. 2018 Aug 1;178(8):1033-1040. doi: 10.1001/jamainternmed.2018.2562.
Cai S, Intrator O, Chan C, Buxbaum L, Haggerty MA, Phibbs CS, Schwab E, Kinosian B. Association of Costs and Days at Home With Transfer Hospital in Home. JAMA Netw Open. 2021 Jun 1;4(6):e2114920. doi: 10.1001/jamanetworkopen.2021.14920.

[10] Levine DM, Ouchi K, Blanchfield B, Saenz A, Burke K, Paz M, Diamond K, Pu CT, Schnipper JL. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77-85. doi: 10.7326/M19-0600.

marginalized groups have similar outcomes as those without these characteristics.[6] Studies have shown that race and ethnicity are not associated with escalation back to the hospital for home hospital patients,[11] and similar lengths of stay and readmissions have been shown among economically disadvantaged and non-disadvantaged patients in home hospital settings.[12] This suggests that home hospital programs may help to overcome traditional barriers that contribute to documented health care disparities. This may be in part due to the presence of clinicians in the patient's home. Receiving hospital-level care in the home setting creates an opportunity for team members to better identify a patient's needs. For instance, when visiting a patient at home, a clinician may be able to recognize the need for additional social services. The clinician can then arrange for appropriate services and supports both during and after the hospitalization.

Home hospital services are transforming the way care is delivered. Patients are able to receive acute treatment in the safety and comfort of their own home. The Medicare AHCAH program has demonstrated positive outcomes and reinforces the need for broader adoption of home hospital programs, many who are waiting for a longer regulatory runway to launch their program. Therefore, ***we urge the Committee to advance legislation to extend for at least 5 years the Medicare Acute Hospital Care at Home (AHCAH) program before it expires on December 31, 2024.***

Thank you for your leadership on this important topic. Our experts are available should you need additional information. Please do not hesitate to contact, Aimee Golbitz, Director of Public Policy and Research, Office of Government Affairs at Mass General Brigham, at agolbitz@mgb.org to answer any questions or connect you with our team.

Sincerely,

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[11] Chou SH, McWilliams A, Murphy S, Sitammagari K, Liu TL, Hole C, Kowalkowski M. Factors Associated With Risk for Care Escalation Among Patients With COVID-19 Receiving Home-Based Hospital Care. Ann Intern Med. 2021 Aug;174(8):1188-1191. doi: 10.7326/M21-0409.
Liu TL, Chou SH, Murphy S, Kowalkowski M, Taylor YJ, Hole C, Sitammagari K, Priem JS, McWilliams A. Evaluating Racial/Ethnic Differences in Care Escalation Among COVID-19 Patients in a Home-Based Hospital. J Racial Ethn Health Disparities. 2023 Apr;10(2):817-825. doi: 10.1007/s40615-022-01270-1.

[12] Siu AL, Zhao D, Bollens-Lund E, Lubetsky S, Schiller G, Saenger P, Ornstein KA, Federman AD, DeCherrie LV, Leff B. Health equity in Hospital at Home: Outcomes for economically disadvantaged and non-disadvantaged patients. J Am Geriatr Soc. 2022 Jul;70(7):2153-2156. doi: 10.1111/jgs.17759.

NHPCO
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March 26, 2024

The Honorable Jason Smith Chairman,
House Committee on Ways and Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, DC 20101

RE: Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Chairman Jason Smith and Members of the Committee:

The National Hospice and Palliative Care Organization (NHPCO) appreciates the opportunity to submit comments for the *Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities*. We appreciate your continued efforts on ensuring patients are able to receive care at home.

NHPCO is the nation's largest membership organization for hospice providers and professionals who care for people affected by serious illness. NHPCO members provide care in more than 4,000 hospice and palliative care locations and care for over two-thirds of the Medicare beneficiaries served by hospice. In addition, hospice and palliative care members employ thousands of professionals and volunteers.

Hospice and palliative care are philosophies of care addressing the whole person, not just physical aspects of health or illness. Both types of care employ an interdisciplinary approach to care with assessments of multiple domains of the human experience (physical, psychological, spiritual, cultural, practical). In addition, hospice and palliative care providers are stalwarts in their community. Hospice is the only Medicare benefit requiring volunteers to be used in day-to-day administrative and direct patient care roles in an amount of at least 5% of the total patient care hours of all paid hospice staff. Incorporating community into caring for the most sick and vulnerable is a core pillar of hospice.

With Medicare accounting for the overwhelming majority of hospice payments, hospice care is at the mercy of the Federal government to continue providing high quality care. Recent research estimates hospices save Medicare $3.5 billion annually when comparing beneficiaries who use hospice and those who do not in their last year of life. Thus, there is a strong financial incentive and the benefits of allowing beneficiaries to access care in their community to invest in and support rural providers.

Congress should embrace and hold up hospice and palliative care as shining examples of delivering the care and attention their communities need, directly into the home. But all of this is at risk. We hear from countless community providers and state association leaders that rural hospices are in financial trouble. We need your help and support!

Hospice and palliative care providers are innovators in the space of care in the home – these providers deliver individualized care to patients and their families, regardless of where the patient is located. Hospice and palliative care providers engage the patient and their loved ones in the care planning process to address pain and symptoms negatively impacting a person's quality of life. Hospice and palliative care empower a patient to take charge of their care and respects the significant role families and caregivers play in supporting and maintaining health and well-being.

Hospice and palliative care providers are advocates and partners with their patients and families. The best way to understand this is through their stories:

- In Texas, a nurse provides care in a county that has not had access to hospice care in decades. She provides the supplies and medical equipment the families need. Nurse Ramirez, who has spent decades living in the county, provides care for her community which would not be served otherwise. Hospice providers are already covering areas of this country underserved by the healthcare system.
- In Iowa during a blizzard, a nurse walked through the storm after a patient's wife called saying there was a change in his condition. Despite the snow being up to her knees, Tiffany made her way to the home then called the sheriff's department to ensure the road was cleared so other members of the family were able to say their goodbyes. Hospice providers are dedicated to their patients and will show up for them when needed.
- In Missouri, a hospice provider understands the importance of being able to access their patients regardless of weather conditions. When they see dangerous weather in the forecast, they activate their emergency plan. They begin to check on patients to ensure they are comfortable and set with supplies. Hospice providers are agile in the care they provide and are ready for whatever is sent their way.
- During the unprecedented fires in Hawaii, hospice providers utilized their expertise in bereavement and caring for the community to support those impacted by the fires. When a community is experiencing terrible loss, hospice providers are equipped to care for them.
- In Minnesota, the interdisciplinary team made sure their patient was able to go to his grandson's wedding. Hospice providers learn patient's goals of care and support the individual and the family in achieving this regardless of the goal being medical, spiritual, or personal.

- In Connecticut, a nurse made sure her patient could reconnect with her beloved horse before passing away. The patient mentioned her wish and the hospice was able to make it happen. The nurse was able to adjust the care the patient needed in order to achieve this final wish. This is holistic, patient-centered care.
- In Arizona, Ryan's House is meeting the need for one of the most underserved patient groups, children with serious illness. Ryan's House is a place for families to receive respite care. Respite care allows families to have a break from round-the-clock home care, spend time with other children in the home, and allow children with serious illness an opportunity to be kids. Hospice providers understand the struggles and needs of caregivers and work to support them.
- Across the country, hospices honor those who have served our nation. Hospices acknowledge the unique needs of Veterans and their families, with some providers even offering Veteran to Veteran volunteer program to honor their patients' service through tailored care and even offering pinning and remembrance ceremonies as they near the end of life.

These stories highlight only a few examples of the extraordinary work hospice and palliative care providers do every day and believe is just "part of the job." In reality, these providers go above and beyond for patients and families to ensure they can be cared for wherever they call home surrounded by the people who love them. Every day, providers show up for their patients by bringing generators to homes without power, bringing water to homes without running water, even accessing remote homes down unpaved roads.

Hospice and palliative care providers are the best of the healthcare system and must be supported and treated as the experts they are in caring for patients at home. The hospice team will show up for the patient – early mornings, late nights, weekends, holidays – to address any symptoms they are experiencing. To be able to do this, these providers must be versed in a variety of services and able to provide these services in a bedroom, living room, or wherever in their home the patient is most comfortable. These creative, innovative providers continue to lead and educate other areas of the healthcare system on how to provide care in the home.

Congress should embrace and hold up hospice and palliative care as shining examples of delivering the care and attention their communities need, directly into the home. But all of this is at risk. We hear from countless community providers and state association leaders that rural hospices are in financial trouble. We need your help and support.

Our previous letters in October 2023 and January 2024 highlight the best way to support these providers:

- **Provide reimbursement more reflective of the care provided**
  - MedPAC has recommended to use all-payer, occupation-level wage data with different occupation weights for the wage index of each type of provider and

reflect local area level differences in wages between and within metropolitan statistical areas and statewide rural areas.
    - Medicare has acknowledged the struggles of rural providers through the Home Health Rural Add-On[1] and this should be extended to hospice providers.
- **Incentivize and support hospitals and nursing homes to utilize care in the home experts**
    - Certain Critical Access Hospitals (CAH) have the flexibility to provide swing bed services by using beds for either acute care or a skilled nursing facility (SNF) level of cares, which are paid based on cost. This flexibility is critical to CAHs' efforts to serve their communities but results in an unintended consequence of lower Medicare payments to CAHs for hospice general inpatient (GIP) care than skilled nursing care.
    - Patients are losing access to important services due to the closure of rural providers and facilities across the healthcare system. Hospice providers need to have nursing facilities and hospitals available to partner with to provide all aspects of the comprehensive hospice benefit. Congress needs to investigate the causes and impacts of these closures as well as find incentives for all providers to enter and stay in rural and frontier communities
- **Support the hospice and palliative care workforce**
    - The Palliative Care and Hospice Education and Training Act (PCHETA) (S. 2243) is crucial to provide much needed funds to expand the pipeline of doctors, nurses, social workers, and chaplains into the hospice and palliative care fields. PCHETA will give providers the support needed to serve an ever growing patient population.
    - Nurse practitioners and physician assistants are essential in covering the gap in providers in rural communities. They must be able to work at the top of their license by allowing them to complete the certification of terminal illness and the administrative face-to-face
- **Expand the use of telehealth to levels used throughout the COVID-19 public health emergency**
    - Make the temporary flexibility allowed for the use of telehealth for face-to-face visits prior to recertification for the hospice benefit allowed through the CARES Act permanent. This flexibility has been extended, including through the Consolidate Appropriations Act, 2023, through CY 2024. Telehealth is appropriate for these low-touch, administrative visits, and increases provider efficiency by reducing drive time for overworked physicians and nurse practitioners.

[1] Section 50208 of the Bipartisan Budget Act of 2018 increased Medicare payments for home health services provided in a rural area. Section 4137 of the Consolidated Appropriations Act of 2023 extended the rural add-on payment policy for calendar year 2023.

- **Support palliative care in the community**.
    - Currently there is no Medicare benefit for palliative care but innovative models such as community based palliative care and the Medicare Care Choices Model can enhance the care patients receive in the home by allowing patient with serious illness and a prognosis longer than six months to receive comprehensive services.

Hospice and palliative care providers who care for rural and underserved communities are committed to caring for their communities despite being faced with lower effective payment rates, facilities closing in the community, and workforce struggles. Congressional support is essential to address these concerns. These providers are dedicated to providing access to quality care to their communities but need partners to investigate and better understand the issues they are facing and help find creative solutions to address them.

What happens to the patient in Iowa, trapped in a snowstorm, when they no longer have access to hospice? Who provides bereavement to a community after a devastating fire in Hawaii? While we might not be located in a large medical building, by providing care and comfort to the dying, hospice is just as critical of infrastructure.

We appreciate your commitment to rural, frontier, and underserved patients, families, and providers and we look forward to collaborating with you to address these challenges to ensure Americans across the country continue to have access to high-quality hospice and palliative care in their community. For any follow up questions, please reach out to me at LHoover@nhpco.org.

Sincerely,

/s/

Logan Hoover
Vice President, Health Policy and Government Relations

PREMIER TRANSFORMING HEALTHCARE TOGETHER®

March 26, 2024

The Honorable Jason Smith
Chairman
House Ways and Means Committee
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Ways and Means Committee
Washington, DC 20515

Submitted electronically via email to WMSubmission@mail.house.gov

Re: House Ways and Means Committee Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Chairman Smith and Ranking Member Neal:

Premier Inc. appreciates the opportunity to submit written comments for the record in response to the House Ways and Means Committee's hearing on enhancing access to care at home in rural and underserved communities. Premier applauds your leadership in this area and strongly supports efforts to develop innovative policy approaches to expand access to this critical and vulnerable population. As discussed in more detail below, Premier highlights opportunities to strengthen the quality and sustainability of care for patients and providers in rural and underserved areas, including:

- Expanding patient access to home infusion care by revising Medicare reimbursement policy for these services;
- Extending key Medicare telehealth flexibilities and the Medicare hospital at home program;
- Promoting financial stability for rural providers;
- Supporting policies that help strengthen the rural healthcare workforce

I. BACKGROUND ON PREMIER INC.

Premier is a leading healthcare improvement company, uniting an alliance of more than 4,350 U.S. hospitals and approximately 300,000 continuum of care providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, consulting and other services, Premier enables better care and outcomes at a lower cost. Premier's sophisticated technology systems contain robust data gleaned from nearly half of U.S. hospital discharges, 812 million hospital outpatient and clinic encounters and 131 million physician office visits. Premier is a data-driven organization with a 360-degree view of the supply chain, working with more than 1,460 manufacturers to source the highest quality and most cost-effective products and services. Premier plays a critical role in the rapidly evolving healthcare industry, collaborating with healthcare providers, manufacturers, distributors, government and other entities to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide. Headquartered in Charlotte, North Carolina, Premier is passionate about transforming American healthcare.

II. IMPROVE PATIENT ACCESS TO HOME INFUSION

Patients served under the Medicare Part B home infusion therapy services benefit are among the country's most vulnerable and often suffer from advanced chronic diseases, such as congestive heart failure, cancer and primary immune deficiency. For decades, home infusion has offered these patients the ability to receive safe and effective care in their homes, which improves their quality of life, minimizes exposure to infectious diseases and provides a more cost-effective option for patients to receive critical medications.

These services are particularly valuable to patients in rural areas who otherwise could be forced to travel significant distance to access care. Unfortunately, the Centers for Medicare & Medicaid Services' (CMS') interpretation of the Medicare home infusion benefit has led to access gaps, which are most prevalent in many rural and underserved areas, as revealed in CMS' own reporting on the program, which shows no home infusion services provided to beneficiaries in Arkansas, Montana, North Dakota, South Carolina, Vermont and Wyoming.

Premier urges Congress to pass The Preserving Patient Access to Home Infusion Act (S.1976/H.R.4104) to promote patient access to home infusion care by aligning Medicare reimbursement policy with the successful model employed by commercial plans.

III. EXTEND ACCESS TO TELEHEALTH

Telehealth was a critical tool during the COVID-19 public health emergency, allowing providers to continue to furnish much-needed services to patients from the safety of their homes. The flexibilities that CMS granted around Medicare telehealth served to highlight that many services can be effectively and efficiently furnished remotely. Congress recognized the value in easing barriers to virtual care and extended several key telehealth flexibilities in the Consolidated Appropriations Act (CAA) of 2023 through the end of calendar year (CY) 2024, as advocated by Premier.

Today, telehealth continues to serve as a means for providers to expand care to many patients who previously had access barriers, particularly in rural and underserved communities. Congressional action, however, is needed to preserve this important care tool, which is especially critical for those using telehealth to reach specialists at longer distances, for access to mental and behavioral health practitioners and those receiving ongoing remote care for chronic conditions. ***Premier urges Congress to further extend the telehealth flexibilities as policymakers continue to evaluate the impact of these policies on patient care.***

As Congress considers extending telehealth flexibilities it is critical that it also extends use of audio-only technology. Nearly a quarter of beneficiaries that received a telemedicine service during the COVID-19 pandemic did so by using audio-only telephone technology in both 2020 and 2021. Accessing video technology can be particularly challenging and creates barriers for beneficiaries who are low-income, elderly or who live in rural areas where the broadband infrastructure cannot support streaming video. The COVID-19 public health emergency (PHE) has highlighted that many services can be effectively delivered as audio-only and do not require a video-connection. ***Premier urges Congress to allow for use of audio-only technology for services where it would be clinically appropriate.*** For example, many patients have benefited from receiving virtual behavioral health services through interactive audio-only technology. CMS could continue to differentiate which services are eligible to be furnished via audio-only as compared to those that require both audio and video technology. CMS should provide stakeholders with the opportunity to weigh in on these lists as part of annual rulemaking.

IV. EXTEND HOSPITAL AT HOME PROGRAM

In November 2020 in response to the COVID-19 pandemic, CMS promulgated the Acute Hospital Care at Home (AHCAH) waiver, which allowed patients to receive certain acute care services from the comfort and safety of their homes. With these flexibilities as the springboard, more than 300 hospitals across 37 states have embraced the "hospital at home" concept and have tailored their programs to meet specific patient and organizational objectives. We appreciate The AHCAH program enables providers to effectively monitor and care for patients as they recover in the comfort of their own homes. This can include remote monitoring capabilities, in-home provider visits, telehealth, medication management and many other care strategies. This new avenue of care has freed up hospital capacity, offered a safe and effective method to care for COVID-19 patients, and reduced avoidable emergency department visits.

We appreciate efforts by Congress to extend these COVID-19 flexibilities through CY 2024 while CMS continues to evaluate the program. Preliminary studies from both CMS and external researchers have found that Medicare patients treated under the CMS hospital at home initiative had low rates of mortality and few hospital readmissions. ***Premier urges lawmakers to further extend the Medicare hospital at home program beyond 2024 at it continues to evaluate how these flexibilities can best support patient access to high quality care in their homes.*** As part of this, Congress should examine alternatives and refinements to the current hospital at home waiver to permit further adoption in rural and underserved areas.

V. ENSURE ADEQUATE PAYMENT TO RURAL PROVIDERS

Health systems and hospitals continue to operate under enormous financial challenges stemming from a combination of increased labor costs, record inflation and lagging reimbursement rates that do not account for these unprecedented financial challenges. The impact of this problem falls disproportionately on facilities in rural and underserved communities, as providers are increasingly sparse in these areas and therefore require a premium to recruit. Premier has expressed significant concerns to CMS that the methodology used to determine annual hospital payment updates does not adequately capture the true costs hospitals have faced over the last few years, especially as it relates to labor. A PINC AI™ analysis found that labor costs have increased by more than 15 percent since the start of FY 2020 through the first half of FY 2023 and do not show signs of returning to a lower level.

Premier urges Congress to develop legislation that requires CMS to reevaluate the data sources it uses for calculating labor costs and adopt new or supplemental data sources that more accurately reflect the cost of labor, taking into account geographic disparities in rural and underserved areas, such as more real time data from the provider community inclusive of contract labor. This would provide a more accurate, blended and aggregated payment adjustment to all hospitals across the nation based upon their true labor costs. Doing this would also allow payments to ebb and flow as needed to account for any readjustments that occur to labor costs in the future.

Additionally, ***Premier recommends Congress develop long-term solutions to stabilize Medicare payments, including eliminating the Medicare sequestration cuts, which have a significant impact on providers in rural and underserved areas***. Congress should also consider how any provider cuts currently being contemplated may inequitably impact rural providers. By establishing policies that create stable, predictable payments for Medicare providers, Congress will help ensure stability for providers in rural and underserved areas and address unjustified geographic payment disparities.

Finally, ***Premier urges Congress to take additional actions to promote provider stability and strengthen access to care for patients in rural areas*** by:

Common conditions it treats include exacerbations of heart failure, asthma, and COPD, respiratory infections such as influenza and COVID-19, and other infections such as cellulitis and complicated urinary tract infections. Home Hospital patients receive comprehensive treatment that involves twice daily in-home care delivered by an integrated team of providers, nurses, paramedics, pharmacists, therapists, and home health aides. Services provided include intravenous fluids and medications, laboratory testing, oxygen, radiology studies, electrocardiograms, ultrasounds, and meals directly in the home. All of this is supported by a 24/7 continuous remote patient monitoring platform that transmits a patient's vital signs to their clinicians as well as a two-way text and video communication pathway that ensures continual access to a patient's clinical team.

In 2020, home hospital programs gained momentum across the country when Medicare launched the Acute Hospital Care at Home (AHCAH) program that provided necessary federal regulatory and financial authorization for these programs to manage the surge in patients during the COVID-19 public health emergency. Participating hospitals admit patients from the emergency department or inpatient beds to their homes. Hospitals must apply to Medicare to participate in the program and adhere to screening and safety protocols. They also submit data on performance and quality. The AHCAH program serves COVID and non-COVID patients. It is slated to expire on December 31, 2024, unless Congress intervenes.

The AHCAH program remains an important tool for hospitals experiencing high demands for inpatient bed capacity even after the pandemic. At Mass General Brigham, almost four years post the start of the COVID-19 pandemic, our hospitals continue to struggle daily with unprecedented overcrowding – particularly in the emergency department. For the past 16 months, the Massachusetts General Hospital Emergency Department has operated nearly every day in "Code Help" or "Capacity Disaster" status, which represents critical levels of emergency department crowding.[4] Our other community hospitals are facing similar capacity issues. In order to meet this ongoing demand, Mass General Brigham has turned to its Home Hospital program. Over the next five years, we expect to shift 10 percent of our inpatient care to patients' homes.

The merits of the home hospital concept have been supported by peer-reviewed clinical studies.[5] Many people recover better at home. On average, home hospital patients tend to have more physical activity, better experience, use less skilled nursing care, and have fewer hospital readmissions.

A recent study led by David Levine, MD, Clinical Director for Research and Development for Mass General Brigham Healthcare at Home, demonstrates the power of the AHCAH model to provide safe, effective, and high-quality care.[6] Levine and his colleagues found low rates of mortality, low use of skilled nursing facilities post-discharge, and low readmission rates. They looked at clinical characteristics and outcomes from all of the 5,858 patients from across the U.S. who were cared for under the AHCAH program, using Medicare fee-

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[4] At Mass General Hospital Code Help" occurs when inpatient beds and monitored hallway stretchers are full, and "Capacity Disaster" is triggered when the Emergency Department is full, all hallway stretchers are being used and there are more than 45 inpatients boarding in the Emergency Department awaiting a hospital bed.

[5] Levine DM, Ouchi K, Blanchfield B, Saenz A, Burke K, Paz M, Diamond K, Pu CT, Schnipper JL. Hospital-Level Care at Home for Acutely Ill Adults: A Randomized Controlled Trial. Ann Intern Med. 2020 Jan 21;172(2):77-85. doi: 10.7326/M19-0600.
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[6] Levine DM, Souza J, Schnipper JL, Tsai TC, Leff B, Landon BE. Acute Hospital Care at Home in the United States: The Early National Experience. Ann Intern Med. 2024 Jan;177(1):109-110. doi: 10.7326/M23-2264.

- ***Reforming Rural Emergency Hospitals (REH) policies.*** Congress established the REH provider designation as an option for rural communities to maintain access to emergency and certain outpatient services in light of potential hospital closures. To date, only 21 hospitals have converted to REH status. While many more hospitals may benefit from this policy, there are statutory restrictions that make the provider type untenable for many rural hospitals. ***Premier encourages Congress to work with stakeholders to address statutory barriers that have limited uptake of the REH provider type to ensure this new provider type is a viable option for rural hospitals and their communities.***

- ***Extending Medicare-dependent hospital (MDH) program and low-volume hospital (LVH) payment adjustment.*** Congress established the MDH program in the late 1980s to support small rural hospitals where Medicare patients made up a significant portion of their inpatient population. The LVH program, which was established in 2005, provides higher Medicare payments to qualifying rural hospitals to help offset the higher costs associated as a result of low inpatient volume. Congress has modified the LVH payment methodology several times in order to allow more hospitals to qualify. Both programs have been critical to ensuring the sustainability of rural hospitals and access to care in rural communities. However, both the MDH program and adjustments to the LVH program expire at the end of CY 2024. ***Premier urges Congress to stabilize rural hospital funding by extending both the MDH program and LVH payment adjustment for multiple years.***

- ***Extend support for Community Health Centers (CHC).*** CHCs increase access to crucial primary care by reducing barriers related to cost, lack of insurance, distance and language for more than 30 million patients nationwide, many in rural and underserved communities. Through the timely delivery of preventative care, CHCs improve the well-being of countless Americans and reduce government spending on healthcare. In addition, CHCs serve on the front lines in our battle against addiction and mental health and are a lifeline for many patients and their communities. The CHC Fund (CHCF) accounts for nearly 70 percent of health center funding and authorization for the program is set to expire at the end of CY 2024. CHC funding is vital to communities nationwide, over half of which are rural. Further, this funding supports CHC data modernization efforts and preparation for future public health emergencies. Funding for CHCs has historically always received bipartisan support in Congress. ***Premier urges Congress to work together to provide stable and strong multi-year funding for CHCs*** which support critical care in underserved areas and play a vital role in America's rural communities***.***

- ***Delay cuts to Medicaid Disproportionate Share Hospital (DSH) Program.*** The Medicaid DSH program was created to help offset uncompensated care costs for hospitals that provide care to large numbers of Medicaid and uninsured patients. These hospitals provide critical services and are economic and healthcare anchors in their communities. More than 2,500 hospitals nationwide receive DSH payments which help keep many hospitals financially viable and able to provide care to vulnerable individuals. The Affordable Care Act (ACA) required reductions to the Medicaid DSH program over time, beginning in FY 2014, under the assumption that the law would increase health insurance coverage and therefore hospitals would be providing less uncompensated care. Unfortunately, the coverage levels anticipated under the ACA have not been fully realized and therefore the levels of uncompensated care provided by DSH hospitals to uninsured and underinsured remains at pre-ACA levels.

  Premier appreciates recent efforts by Congress to delay the onset of these cuts until January 1, 2025. ***Premier urges Congress to act before the end of the year to prevent the pending***

Medicaid DSH cuts once again for at least two years and protect access to care for our nation's most vulnerable patients.

- ***Reauthorize the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act:*** The SUPPORT Act, which passed in 2018 with robust bipartisan support, has been instrumental in helping our nation address the opioid epidemic through programs and policies that impact treatment, prevention and recovery. Unfortunately, the SUPPORT Act authorization lapsed as of Sept. 30, 2023. The ongoing opioid epidemic continues to overwhelm hospitals with an estimated 66 million emergency department visits and 760,000 inpatient admissions each year. ***Premier urges Congress to reauthorize the SUPPORT Act to reduce barriers to receiving and delivering care for substance use disorders*** by improving payment policies (including those that promote telehealth services), reducing unnecessary regulatory and administrative burden for providers and strengthening the behavioral healthcare workforce.

VI. STRENGHTEN RURAL HEALTHCARE WORKFORCE

The healthcare workforce is currently experiencing severe shortages because of unprecedented pressures exacerbated by the pandemic, pushing our healthcare system to its limits. Projections by the Association of American Medical Colleges (AAMC) show that physician demand will grow faster than supply leading to a projected total physician shortage of up to 124,000 physicians by 2034. These shortages will have real impact on patients, particularly those living in rural and underserved communities. In addition to the physician workforce, we must also take steps to bolster the ranks of non-physician clinical roles, including nursing, but also other vital roles such as pharmacists, occupational therapists, respiratory therapists and more. ***Premier believes addressing workforce shortages requires a multi-pronged approach and urges Congress to take the following actions***:

- ***Extending workforce training programs.*** The Teaching Health Centers Graduate Medical Education (THCGME) program, the Children's Hospital Graduate Medical Education Program (CHGME) and the National Health Service Corps (NHSC) program are not only fundamental for tackling the healthcare labor shortage, but they provide essential and comprehensive services for rural and tribal communities as well as children nationwide. These programs expand our ability to deliver primary care across the country and are fundamental to tackling the healthcare labor shortage. Premier appreciates recent legislation to extend many of these programs through CY 2024. ***Premier urges Congress to continue its record of bipartisan support for workforce training programs and provide stable multi-year funding for these programs***. Congress should also consider support for "earn while you learn" programs that support the growth and development of healthcare workers while employed in a healthcare facility.

  Additionally, under the Conrad 30 program, each state is allocated 30 waivers that exempt J-1 physicians from the requirement to return to their country of origin in exchange for three years of service in an underserved community. While a temporary extension of the program's authorization until Sept. 30, 2024 was also recently enacted, Premier urges Congress to further extend this program which has helped Americans in rural and underserved areas receive medical care.

- ***Investing in residency training.*** To help grow a sustainable physician workforce to meet patient needs, increased Medicare support for graduate medical education (GME, or residency training) is needed. ***Premier urges Congress to take additional action to increase Medicare-supported GME slots by passing the bipartisan Resident Physician Shortage Reduction Act of 2023***

(H.R. 2389). This legislation which would gradually raise the number of Medicare-supported GME positions by 2,000 per year for seven years, for a total of 14,000 new positions. These new GME positions would target teaching hospitals with varied needs, including hospitals in rural areas and hospitals serving patients from federally-designated health professional shortage areas.

- ***Boosting non-physician pipeline.*** An issue Premier frequently hears with respect to nursing shortages is that the pool of willing candidates exceeds the number of available training slots in schools of nursing, at least partly due to limited number of available training faculty. ***Premier encourages Congress to consider ways to increase training facility capacity,*** including examining whether all educators in such programs should require an advanced degree or if there are opportunities for flexible standards that might create additional training capacity if some educators are permitted to have a bachelor's degree only for example. ***Premier also recommends that Congress seek opportunities to provide support to grant programs that expand vocational programs to help train advanced practice providers, such as nurse practitioners, and other clinical roles that do not require four-year degrees, such as home health aides; nursing assistants; or technicians for pharmacy, radiology and laboratory***. Premier additionally encourages Congress to support approaches and programs that connect high school students to health careers by enhancing recruitment, education, training and mentorship opportunities. Inclusive education and training experiences expose students and providers to backgrounds and perspectives other than their own and heighten cultural awareness in healthcare, resulting in benefits for all patients and providers. Studies also show that underrepresented students are more likely to serve patients from those communities.

- ***Reforming loan forgiveness programs.*** Loan forgiveness programs should be considered to incent new talent to join the field. However, in many cases healthcare workers opt to not accept loan forgiveness funds because they are accounted for as income and can have a detrimental impact on an individual's finances if pushed into a higher tax bracket. Similarly, healthcare workers are often hesitant to accept employer assistance funds as they can also be counted as income and force the worker into a "benefit cliff." Therefore, ***Premier urges Congress to ensure that the tax implications of loan forgiveness programs do not act as inadvertent disincentives to individuals participating.***

VII. CONCLUSION

In closing, Premier appreciates the opportunity to submit these comments in response to the Ways and Means Committee's hearing on enhancing access to care at home in rural and underserved communities. Please consider Premier and our significant cohort of rural providers a resource as you continue this important work. If you have any questions regarding our comments or need more information, please contact Melissa Medeiros, Senior Director of Policy at melissa_medeiros@premierinc.com.

Sincerely,

Soumi Saha, PharmD, JD
Senior Vice President of Government Affairs
Premier Inc.

March 25, 2024

The Honorable Jason Smith
Chairman, House Committee on Ways & Means
U.S. House of Representatives
1139 Longworth House Office Building
Washington, D.C. 20515

Re: Comments for the Record of the Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Dear Chairman Smith:

Pritikin ICR LLC ("Pritikin") appreciates the opportunity to submit comments for the Ways and Means Committee hearing on Enhancing Access to Care at Home in Rural and Underserved Communities, which was held on March 12, 2024. Pritikin is a St. Louis, Missouri based company that partners with health systems, hospitals, and physicians to provide an intensive cardiac rehabilitation ("ICR") program that reverses or slows the progression of heart disease after an acute cardiac event. **We are writing today to urge the committee to support "*The Sustainable Cardiopulmonary Rehabilitation Services in the Home Act,*" H.R. 1406**. This important legislation which would restore patient access to participation in virtual CR and ICR programs from the beneficiary's home and foster participation in CR and ICR for those in rural and underserved communities.

The Pritikin ICR Program uses an evidence-based curriculum of exercise, heart healthy nutrition and healthy mindset workshops to improve patient outcomes for cardiac patients. It is one of only three ICR programs certified by the Centers for Medicare and Medicaid Services (CMS) for coverage under Medicare's ICR benefit. The ICR benefit allows up to seventy-two sessions of ICR, which are focused on exercise and immersive workshops, engaging cooking classes, and individualized consultations with registered dietitians, nurses, exercise physiologists, social workers, psychologists, and health coaches. Patients who participate in the program have experienced improved outcomes including a reduced need for coronary bypass surgery, slowed disease progression, lower risk factors for coronary artery disease, and reduced key clinical indicators of disease progression including blood pressure and cholesterol. Importantly, the Pritikin ICR Program has proven to be as effective when delivered virtually through two-way audio-visual synchronous communication as when it is delivered on-site at a facility.

Heart disease is the leading cause of death in this country and enacting H.R. 1406 would contribute to addressing the disparities in cardiac health affecting both rural and underserved areas. CR and ICR are evidence-based treatments specifically designed to reduce the burden of cardiac disease. Indeed, the Million Hearts Initiative, an effort co-led by the Centers for Disease Control ("CDC") and Centers for Medicaid & Medicare Services (CMS) set a goal to avert one million heart attacks and strokes by the end of 2027 and identified increased participation in cardiac rehabilitation as a

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key component of achieving its goal. The Million Hearts Initiative recommended increasing participation in cardiac rehabilitation to 70% of eligible patients from the current rate of approximately 20-25% of eligible patients. CMS identified CR and ICR as "underutilized" and "high-value" services and outlined a goal of extending these services to patients in access deserts and other underserved areas in the 2023 Medicare Physician Fee Schedule proposed rule[1]. Passing HR 1406 is one way to realize the goals of the Million Hearts Initiative and CMS.

Experience delivering CR and ICR during the Public Health Emergency ("PHE") demonstrates virtual delivery of CR and ICR can be just as effective as facility-based services. Virtual patients are able to access essential information, engage directly with their providers and use common items from their home to participate in the sessions. Unfortunately, the ability for hospitals to provide virtual CR and ICR within the Medicare program ended with the PHE and coverage for physician practices to provide virtual CR services will cease at the end of 2024. Many patients living in rural or underserved areas who were successfully accessing these services from their home because they did not have the time or financial resources to travel to a facility were abruptly cut off from those services. Restoring the ability for patients to take part in CR and ICR programs remotely via telehealth technology would help to reach more patients in underserved areas, help to alleviate the burden of heart disease in those communities, reduce long-term health care costs, and improve overall health in these communities.

Receiving cardiac rehabilitation virtually was shown during the PHE to be as safe and effective as facility-based delivery and resulted in equal or better outcomes for patients. In many studies which directly compare virtual to center-based cardiac rehabilitation, there is no difference across the following key outcomes measures: (a) exercise capacity, (b) mortality and morbidity, (c) modifiable risk factors, (d) health-related quality of life, and (e) adherence. Some studies show that outcome measures are actually *better* in virtual cardiac rehabilitation. Virtual cardiac rehabilitation is a critical and effective tool to improve patient outcomes and allows providers to reach cardiac rehabilitation patients regardless of where they live.[2]

The real-world experience of our provider partners in delivering ICR and CR during the COVID-19 PHE directly demonstrates how virtual CR and ICR may support access and improvements in cardiac health in rural and underserved communities. According to the directors of the cardiac rehabilitation programs that offered virtual cardiac rehabilitation services, virtual CR and ICR is equally or more effective than facility-based programs on every clinical measure, and a greater percentage of patients see the program to completion. The patients have also shed light on the significant barriers to in-person CR. ***At one location, most of the patients who participated virtually reported living over sixty miles from the facility and indicated that they would not have participated in cardiac rehabilitation at all if they had to travel to a facility to receive the care in-person***. These patients cited transportation hurdles, distance, the cost of gas, and the significant travel time, combined with work or family responsibilities as obstacles to getting to a facility-based program.

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[1] https://www.cdc.gov/heartdisease/facts.htm.

[2] "Cardiac Rehabilitation and Implications During the COVID-19 Era," acc.org, American College of Cardiology, 4 January 2021, https://www.acc.org/Latest-in-Cardiology/Articles/2021/01/04/14/03/Cardiac-Rehabilitation-and-Implications-Duringthe-COVID-19-Era.

The clinical literature supports what ICR providers' firsthand experience shows: cardiac rehabilitation services are both safe and effective when they are delivered virtually. For example, a January 2021 publication from the American College of Cardiology concludes that "available data suggest that HBCR (home-based (or virtual) cardiac rehabilitation) is equivalent to CBCR [center-based cardiac rehabilitation]."[3] During the COVID-19 pandemic in Canada and Japan, virtual cardiac rehabilitation programs were "found to be as effective as on-site programs offered in hospitals."[4] And a recent study published by the American Heart Association concluded that the mean change in 6-minute walk test distance (to assess exercise capacity) was significantly *greater* for patients enrolled in virtual cardiac rehabilitation than in center-based rehabilitation (+101 versus +40 m; $P<0.001$).[5]

H.R. 1406, "*The Sustainable Cardiopulmonary Rehabilitation Services in the Home Act,*" would restore a patient's ability to participate in CR and ICR in the home, a tool that was safely and effectively utilized during the pandemic. Restoring the ability for in-home CR and ICR would increase access for patients in rural and underserved areas and take a crucial step toward realizing the Million Hearts' goal of 70% uptake of CR services. This legislation has strong bipartisan support, and it would enable comprehensive access to a service proven to reduce the risk of future hospitalizations and future cardiac events for people with heart disease. Importantly, H.R. 1406 would also promote patient choice by allowing Medicare beneficiaries the flexibility to receive CR or ICR at a center or in their own home. We urge you to adopt this legislation to implement virtual CR and ICR, a straightforward and proven mechanism to provide CR services that may not be otherwise available to patients in rural and underserved areas.

Thank you for your efforts to increase access to health care services in the home. We would welcome the opportunity to discuss the experiences of our provider partners and their patients with virtual cardiac rehabilitation services delivered in the home. Should you have any questions in the meantime, please reach out to Shelagh Foster at sfoster@polsinelli.com.

Sincerely

[3] "Cardiac Rehabilitation and Implications During the COVID-19 Era," acc.org, American College of Cardiology, 4 January 2021, https://www.acc.org/Latest-in-Cardiology/Articles/2021/01/04/14/03/Cardiac-Rehabilitation-and-Implications-Duringthe-COVID-19-Era.

[4] "Remote cardiac rehabilitation programs are effective alternatives to on-site services," heart.org, American Heart Association, 9 November 2020, https://newsroom.heart.org/news/remote-cardiac-rehabilitation-programs-are-effectivealternatives-

[5] "Effects of Home-Based Cardiac Rehabilitation on Time to Enrollment and Functional Status in Patients With Ischemic Heart Disease," ahajournals.org, American Heart Association, https://www.ahajournals.org/doi/10.1161/1AHA.120.016456.

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NATIONAL HEALTH COUNCIL

March XXX, 2023

The Honorable Jason Smith
Chair
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
United States House of Representatives
Washington, DC 20515

Dear Chairman Smith and Ranking Member Neal:

The National Health Council (NHC) thanks the House Committee on Ways and Means for holding a hearing on March 12, 2024, titled, "Enhancing Access to Care at Home in Rural and Underserved Communities." **We particularly commend you for featuring two patients speaking directly about their lived experiences.** Too often, these discussions that directly affect patients do not include the patient perspective, and we appreciate the Committee doing so. People with chronic diseases and disabilities often face significant logistical, economic, and other challenges to accessing care in clinical settings. They are also at heightened risk of facing infections, contagious diseases, and other perils of entering a health care facility. The NHC supports efforts to increase access to needed treatments in the home including things like increased access to telehealth and care in the home such as home dialysis and hospital at home.

Created by and for patient organizations more than 100 years ago, the NHC brings diverse organizations together to forge consensus and drive patient-centered health policy. We promote increased access to affordable, high-value, sustainable, equitable health care. Made up of more than 170 national health-related organizations and businesses, the NHC's core membership includes the nation's leading patient organizations. Other members include health-related associations and nonprofit organizations including the provider, research, and family caregiver communities; and businesses representing biopharmaceutical, device, diagnostic, generic drug, and payer organizations.

Access to telehealth is one of the most popular, bipartisan, and patient-centric solutions to increasing access to care. The COVID-19 pandemic highlighted and underscored the benefits of telehealth in providing increased access, ease of use, and comfort with the health care system for patients with chronic diseases and disabilities. To help quantify the patient needs in telehealth, the NHC conducted eight 30-minute listening sessions with staff from the NHC's patient-organization members[1]. These listening sessions demonstrated the extent that patients value access to telehealth. One of the key themes that arose during the listening sessions was that telemedicine can help reduce disparities; however, if it is done incorrectly, it can also exacerbate disparities. Another theme was that patients should be able to voice their preference for the type of provider visit they can have, whether it is in-person, on the phone, or virtually. Concerns over

[1] NHC-Telemedicine-Briefing-one-pager.pdf (nationalhealthcouncil.org)

transportation, mobility, condition type, geography, and privacy could all change a patient's preference.

While doctors' offices are operating similar to before the pandemic, the promise of telehealth is as real as ever for patients living in rural and underserved communities, those with mobility and transportation limitations, people with rare diseases working with far away specialists, the immunocompromised, and many others.

Telehealth should be an option for patients and providers, when preferred and clinically appropriate. Making current Medicare telehealth authority permanent to ensure continuity of care and access to medically necessary services for Medicare beneficiaries should be a top priority for Congress before the current authorities expire later this year. In addition, payment policies, including cost-sharing requirements, and provider networks must still support access and in-person availability when preferred and clinically appropriate.

During the pandemic, the NHC joined 34 other national patient advocacy and health organizations on a set of Principles for Telehealth Policy. The NHC urges you to use these principles as a guide for any telehealth legislation in order to ensure that the needs of patients are met.

First, telehealth policy can improve access through equitable coverage, with services covered by all health plans including, but not limited to, Medicare, Medicaid, the ACA Marketplace, and other federal and state regulated commercial health plans.

Second, telehealth policy should ease technology barriers. Telehealth services should be equitably available through easily usable technologies that are accessible to people with disabilities, with limited English proficiency, and limited technology. The option of audio-only communication is especially important for rural and low-income populations, as many of these patients lack internet access.

Third, telehealth policy should preserve and promote patient choice. A patient should have the opportunity and flexibility to choose whether they will access care in-person or via telehealth technologies. In addition, patients should have limited out-of-pocket costs for telehealth services and be no more than what they would pay for an in-person visit. Insurers should not incentivize nor disincentivize patients from using one care site over another — the choice should be based on the right care setting for the patient's individual needs.

Fourth, telehealth policy should remove geographic restrictions, which place a burden on and can limit both patients and providers when evaluating treatment options for optimal care. This includes allowing providers to practice across state lines through telehealth services increasing access to care and improve care coordination for patients, particularly in underserved areas.

National Health Council Statement for the Record
U.S. House of Representatives Committee on Ways and Means Hearing
"Enhancing Access to Care at Home in Rural and Underserved Communities"
March XX, 2024

Recommendation: Make the current Medicare telehealth flexibilities permanent. And address payment and regulatory barriers that limit access to telehealth while preserving access to in-person care when preferred and/or needed.

Better access to health care equals better outcomes in the long run — ultimately reducing cost — and telehealth is proving to be a valuable tool that should be protected and enhanced in this regard.

Please do not hesitate to contact Eric Gascho, Senior Vice President of Policy and Government Affairs, if you or your staff would like to discuss these issues in greater detail. He is reachable via e-mail at egascho@nhcouncil.org.

Sincerely,

Randall L. Rutta
Chief Executive Officer

Partnership to Advance Virtual Care

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March 13, 2024

Submitted via email

House Committee on Ways and Means
1139 Longworth House Office Building
Washington, DC 20515

Re: March 12, 2024 Hearing on "Enhancing Access to Care at Home in Rural and Underserved Communities"

Dear Chairman Smith and Ranking Member Neal—

The Partnership to Advance Virtual Care (PAVC) is pleased to submit this statement for the record following the committee's March 12, 2024 hearing titled "Enhancing Access to Care at Home in Rural and Underserved Communities."

PAVC's Background and Mission

PAVC is comprised of health systems, health IT vendors, chronic care specialists, behavioral health providers, and primary care stakeholders that are leading innovation in telehealth care delivery. We focus the collective voice of the industry to advocate for regulatory and legislative policies that improve access to and delivery of virtual health services.

The nation's healthcare system has evolved significantly over the last few years, creating opportunities for rapid progress. During the pandemic, enhanced access to telehealth services served as a lifeline to patients across the country, allowing patients to access critical health care services while keeping vulnerable patients out of clinics and hospitals. Virtual care continues to play a vital role in our health care delivery system, ensuring continued access to high-quality health care services and to improve health equity. These services should continue to be leveraged in order to enhance patient experiences, improve health outcomes, and reduce health care costs.

Permanent Extension of Medicare Telehealth Flexibilities

PAVC appreciates the committee's focus on virtual care access for Medicare beneficiaries. While the Consolidated Appropriations Act, 2023 (CAA, 2023) extended key telehealth flexibilities through December 31, 2024, it is imperative that Congress address these extensions prior to the expiration date. As noted in its final CY 2024 Medicare Physician Fee Schedule (PFS)

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rule, the Centers for Medicare and Medicaid Services (CMS) has stressed its limited ability to provide coverage and payment beyond the current December 31, 2024, expiration date. Without further congressional action on these provisions, CMS' ability to contemplate changes for CY 2025 and beyond will be hindered. Enacting legislation to further extend Medicare telehealth provisions in advance of the release of the proposed PFS rule for CY 2025—which is expected in July 2024—would ensure the least amount of disruption for patients and providers alike.

Consistent with PAVC's mission, we urge the committee to consider and advance legislation that would permanently extend pandemic-era Medicare telehealth flexibilities. The key Medicare telehealth flexibilities extended through December 31, 2024, by the CAA, 2023 include:

- Waivers to the geographic and originating site restrictions
- Expansions to the list of eligible practitioners
- Eligibilities for federally qualified health centers (FQHCs) and rural health clinics (RHCs)
- Allowing telehealth to be provided through audio-only telecommunications
- Allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care
- Delaying the in-person visit requirement before a patient receives tele-mental health services.

PAVC was pleased this two-year extension was enacted, as it provides some length of certainty for patients and providers. However, permanency remains a priority and the extension deadline is quickly approaching. PAVC has identified the following legislative barriers that would severely restrict patient access to care through telehealth if not permanently changed:

- ***Geographic and originating site restrictions.*** Before the pandemic, Medicare required that the patient be located in a rural or certain health professional shortage area and use telehealth in an approved originating site, such as a hospital or physician office. Together, these restrictions functionally prevent beneficiaries from accessing telehealth from a variety of appropriate and more accessible locations, including their home. Only about two percent of beneficiaries reside in zip codes that meet the traditional geographic and originating site criteria.

- ***Qualifying providers.*** Under current policy, the CMS would have to revert back to policies that restrict the types of providers that can deliver reimbursable care virtually to Medicare beneficiaries. Commonly accessed providers like physical therapists, occupational therapists, and speech language pathologists would no longer be able to bill for telehealth services.

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- ***FQHC and RHC expansion.*** Without this COVID-19 flexibility, FQHCs and RHCs will not be allowed to serve as distant site telehealth providers. This would prevent low-income and geographically isolated individuals from utilizing telehealth visits to maintain continuity of care with their existing provider or connect with clinicians best equipped to meet their needs. This would create barriers to affordable treatment for the rural and underserved populations who often need it most.

- ***Audio-only communications.*** Permanently allowing telehealth to be provided through audio-only communications is an important component of ensuring continued access to care. This is particularly relevant in rural communities, where unavailable or unreliable broadband access could preclude patients from accessing telehealth through other means.

- ***Face-to-face requirement for hospice care.*** Permanently allowing telehealth to be used for a required face-to-face encounter prior to the recertification of a patient's eligibility for hospice care is another component of ensuring continued access to care, particularly in isolated rural and underserved communities.

- ***In-person requirement for mental telehealth services.*** Enhanced access to mental telehealth services during the pandemic improved the lives of many Medicare patients across the country. This included waiving the in-person requirement for telehealth treatment of certain mental health conditions. There is no compelling clinical reason to legislatively mandate an in-person visit for all Medicare patients for the expanded range of eligible mental health services. Whether a patient requires an in-person visit prior to commencing their tele-mental health treatment should be left to the clinical judgment of their health care provider. The nature of mental and behavioral health care services does not require in-person assessments with legislated frequency. In cases where an in-person visit would be warranted, providers can exercise their clinical judgment.

Taken together, the extension of these provisions will allow for continued progress toward wider adoption and utilization of telehealth for Medicare providers and beneficiaries in a post-PHE health care system. PAVC encourages the committee to advance these policy extensions.

Permanent Extension of HDHP Safe Harbor (H.R. 1843)

We understand the focus of this hearing was on policies and programs for Medicare beneficiaries. However, it is important for the committee to continue to consider telehealth flexibilities outside of Medicare that are also set to end on December 31, 2024. The safe harbor

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for first-dollar coverage for telehealth services for those with health savings account (HSA)-eligible high deductible health plans (HDHPs) has allowed employers and health plans to provide coverage for telehealth services on a pre-deductible basis for the more than 32 million Americans with HSA-eligible HDHPs.

This commonsense policy has helped ensure families could access vital telehealth services—including virtual primary care and behavioral health services—prior to having met their deductible. The ability to offer pre-deductible telehealth services for employees is a meaningful expansion of health care access and is popular among consumers. Notably, according to unpublished estimates from Employee Benefit Research Institute (EBRI), over 50 percent of individuals with an HSA live in zip codes where the median income is below $75,000 annually. This flexibility also enabled expansions of access to care for individuals who may otherwise have neglected essential care due to high out-of-pocket costs. Further, a survey by NORC and AHIP found that "73 percent of commercial telehealth users said Congress should make permanent the provisions that allowed for coverage of telehealth services before paying their full deductible."

PAVC strongly supports the Telehealth Expansion Act (H.R. 1843) and thanks the committee for favorably passing this legislation on June 13, 2023. We encourage the committee to include this policy in any broader virtual care efforts this year to ensure that this important source of patient access does not lapse.

Summary and Conclusion

The COVID-19 pandemic greatly accelerated the adoption of virtual care delivery. Advances in telehealth have made health care more accessible and equitable nationwide, and PAVC strongly believes that these advances should remain part of our health care system.

We welcome the opportunity to discuss these issues further. Please do not hesitate to contact me directly if PAVC can serve as a resource to the committee, as you work to advance legislation addressing telehealth policy.

Respectfully,

Rachel Stauffer
Executive Director
Partnership to Advance Virtual Care

AMERICAN OSTEOPATHIC ASSOCIATION

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Statement for the Record

Ways and Means Committee Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

March 12, 2024

On behalf of the American Osteopathic Association (AOA), and the more than 186,000 osteopathic physicians (DOs) and medical students we represent, we write to express our appreciation for the Committee's interest in improving patient access to care, and making meaningful strides toward addressing the substantial gaps in access to care for patients in rural communities. This is a particularly important opportunity to provide insight on matters impacting osteopathic physicians and our patients. DOs represent 11% of all physicians in the United States, but comprise nearly 40% of physicians working in rural and underserved areas.

Among the core principles of osteopathic medicine are providing patient-centered, coordinated care across the health care spectrum. We recognize that health care stakeholders across the United States share the responsibility of promoting reforms and policies that ensure individuals and families have access to coverage and high-quality care when and where they need it. As such, the AOA unequivocally believes that telehealth and at-home care are integral to reducing barriers to access for patients in rural and underserved communities. These patients face hospital and physician office consolidations and closures, requiring them to travel substantial distances to receive the care they need. While Congress has implemented temporary flexibilities to telehealth and health at home services, physicians and their patients need lasting solutions to improve the health and well-being of individuals in rural America.

Medicare Telehealth Modernization Act

The decision to expand telehealth flexibilities during the COVID-19 public health emergency (PHE), and the subsequent extension of those flexibilities in 2022, has allowed millions of Americans to access high-quality care they otherwise would not have been able to receive. The AOA is sincerely appreciative that the Committee and Congressional leaders have extended Medicare's telehealth coverage flexibilities through CY2024, and strongly encourage the Committee to work toward a long-term reauthorization that would provide clarity and certainty for the future of telehealth.

The expansion of telehealth coverage has allowed for patients to have better access to the care they need when they need it and supports physicians in building longitudinal relationships with their patients. Congress can improve access to care by passing the *Telehealth Modernization Act* and making permanent the flexibilities that were established during the COVID-19 public health emergency and extended via the *Consolidated Appropriations Act of 2023*. Some of these critical flexibilities to expand payment for telehealth services include allowing Medicare patients to receive telehealth services in their home, eliminating site and geographic restrictions for non-behavioral health services, permitting the delivery of telehealth via audio-only technology, and allowing federally qualified health centers and rural health clinics to serve as distant sites services other than behavioral health services. Ensuring appropriate coverage and payment for telehealth will enable physician practices to leverage this modality in providing longitudinal care and to sustain

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these vital services into the future. Moreover, it will support improved access to specialists and mental health services that are otherwise inaccessible for the vast majority of patients in rural and underserved communities.

Further, the AOA supports the bipartisan *Telehealth Expansion Act (H.R.1843),* which would improve patient access to telehealth services by allowing first dollar coverage for beneficiaries with Health Savings Accounts (HSA) and enrolled in a High Deductible Health Plan, which the Committee recently passed. Evidence shows that physicians are able to deliver clinically equivalent care via telehealth for many conditions, increasing the number of patients physicians can see in a given day, and reducing potential access burdens for patients.[1] Additionally, demand for telemedicine remains high post-COVID-19 PHE, especially for mental health services.[2]

Access to Home-Based Longitudinal Care

Telemedicine provides physicians the flexibility they need to build and maintain strong, lasting relationships with their patients. Longitudinal, high-quality care requires consistent contact between patients and providers. This can be especially difficult for patients with physical mobility issues and for those without regular access to a reliable transportation option that can limit access to in-person care. However, 22% of rural Americans do not have access to broadband internet, which can limit their access to critical healthcare services, including telehealth and remote monitoring services.[3]

Similarly, remote patient monitoring also allows physicians to more effectively monitor the health of patients, particularly those with chronic conditions, but it is nearly impossible without adequate broadband access for patients. Chronic conditions such as heart disease and chronic lower respiratory disease are much more prevalent in rural areas, and are a leading cause of death and disability.[4] By ensuring physicians can utilize RPM for rural patients with chronic diseases, we can reduce hospital admissions, improve quality of life, and improve outcomes for patients.

Moreover, expanded support for hospital at home (HaH) programs would enable patients to receive care at home with regular support and contact from physicians. Hospitals and other inpatient settings are not only more costly sites of care, but present risks to immunocompromised patients, particularly those with chronic conditions. There is significant evidence that at-home treatment that is effectively monitored by a physician-led care team can be safer, cheaper, and deliver better outcomes – particularly for patients most at risk for hospital-acquired infections or chronic disease regressions.[5] We encourage the Committee to work to extend the Medicare Acute Hospital at Home (AHCaH) waiver to ensure future patients can receive HaH care, and protect current HaH patients access to the care they currently receive.

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[1] Baughman DJ, Jabbarpour Y, Westfall JM, et al. Comparison of Quality Performance Measures for Patients Receiving In-Person vs Telemedicine Primary Care in a Large Integrated Health System. *JAMA Netw Open.* 2022;5(9):e2233267

[2] Kaiser Family Foundation. "Telehealth Has Played an Outsized Role Meeting Mental Health Needs During the COVID-19 Pandemic." 2022

[3] USDA. "e-Connectivity for all rural Americans is a modern-day necessity." 2023.

[4] Centers for Disease Control. "Rural health." 2023

[5] B. Leff, L. Burton, S. L. Mader et al., "Hospital at Home: Feasibility and Outcomes of a Program to Provide Hospital-Level Care at Home for Acutely Ill Older Patients," *Annals of Internal Medicine*, Dec. 2005 143(11):798–808.

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With the demonstrated successes of telemedicine and hospital at home programs, the Committee should enact policy reforms that both ensure long-term success in care delivery and patient outcomes.

Physician Workforce Sustainability

Physicians across the country face ongoing uncertainty regarding the payment they will receive for services rendered year after year. This year, in the Medicare Physician Fee Schedule, CMS finalized a 3.37% cut to Medicare's physician payments. This cut coincides with ongoing increases in costs to practice Medicine – which CMS acknowledges, as the projected increase in the Medicare Economic Index (MEI) for 2024 will be 4.6%. This presents an existential threat to small and independent physician practices across the country, particularly those in rural and underserved communities.

Unlike nearly all other Medicare providers and suppliers, physicians do not receive an annual inflationary payment update. A change to add an annual inflationary payment update would provide stability to independent physician practices facing unique economic challenges in rural areas. This type of reform has previously been proposed through the bipartisan *Strengthening Medicare for Patients and Providers Act* (H.R.2474), and **the AOA strongly urges the Committee to consider this legislation further.** AOA also recommends further supplementing support for rural physicians by utilizing economic levers that would make practicing in rural and underserved communities more accessible and appealing to a broader base of physicians. These levers include increasing Physician Health Professional Shortage Area incentives and/or creating new means of improving payment specifically for rural physicians. Without predictable inflationary payment updates and additional incentives for rural and underserved communities, access to care for Medicare beneficiaries will continue to be in jeopardy.

We urge the committee to take proactive steps to ensure continued patient access to care by creating predictable and sustainable payment structures for the current physician workforce, and using policy levers to build the workforce of the future. We urge the Committee to consider the bipartisan *Rural Physician Workforce Production Act* (H.R.834), which would allow certain hospitals to receive additional payments from Medicare for employing resident physicians in rural areas. This would increase the number of physicians practicing in rural communities and would provide financial support to make these residencies more feasible. Similarly, the AOA strongly supports the *Resident Physician Shortage Reduction Act* (H.R.2389). This bipartisan legislation would add a total of 14,000 new graduate medical education positions over the course of seven years.

Conclusion

Again, thank you for the opportunity to submit comments for the record. The Committee's work on these important issues will support the stability of both the physician workforce and patient access to affordable, high-quality care. The AOA and our members stand ready to assist the Committee at large as you consider new policies and legislation to improve patient access to care and minimize red tape for doctors. If you have any questions or if the AOA can be a resource, please contact AOA Vice President of Federal Affairs and Public Policy, John-Michael Villarama, MA, at jvillarama@osteopathic.org, or (202) 349-8748.

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American Association of Nurse Practitioners
Statement for the Record
Enhancing Access to Care at Home in Rural and Underserved Communities
House Committee on Ways and Means
March 12, 2024

The American Association of Nurse Practitioners (AANP), representing the 385,000 Nurse Practitioners (NPs) in the United States, appreciates the opportunity to provide a statement for the record for the House Committee on Ways and Means hearing entitled "Enhancing Access to Care at Home in Rural and Underserved Communities." AANP is committed to empowering all NPs to advance high-quality, equitable care, while addressing health care disparities through practice, education, advocacy, research, and leadership (PEARL).[1] We appreciate the Committee's attention to the importance of enhancing access to care for patients in rural and underserved communities and thank Chairman Smith and ranking member Neal for holding this hearing. Members and the expert witnesses correctly highlighted the many policy changes needed to better ensure access to care, including the removal of longstanding and antiquated barriers within the Medicare program.

This issue is of particular importance to our members, as NPs provide a substantial portion of the high-quality[2], cost-effective[3] care that our communities require. As of 2021, there were over 193,000 NPs billing for Medicare services, making NPs the largest and fastest growing Medicare designated provider specialty.[4] Approximately 42% of Medicare patients receive billable services from a nurse practitioner[5], and approximately 80% of NPs are seeing Medicare and Medicaid patients.[6] According to the Medicare Payment Advisory Commission (MedPAC), APRNs and PAs comprise approximately one-third of our primary care workforce, and up to half in rural areas.[7]

NPs also provide a substantial portion of health care in rural areas and areas of lower socioeconomic and health status. As such, they understand the barriers to care that face vulnerable populations on a daily basis.[8],[9],[10] They are also "significantly more likely than primary care physicians to care for vulnerable populations. Nonwhites, women, American Indians, the poor and uninsured, people on Medicaid, those living in rural areas, Americans who qualify for Medicare because of a disability, and dual-eligibles are all more likely to receive primary care from NPs than from physicians."[11]

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[1] https://www.aanp.org/advocacy/advocacy-resource/position-statements/commitment-to-addressing-health-care-disparities-during-covid-19https://www.aanp.org/about/about-the-american-association-of-nurse-practitioners-aanp/strategic-focus.
[2] https://www.aanp.org/images/documents/publications/qualityofpractice.pdf.
[3] https://www.aanp.org/images/documents/publications/costeffectiveness.pdf.
[4] data.cms.gov MDCR Providers 6 Calendar Years 2017-2021.
[5] *Ibid.*
[6] NP Fact Sheet (aanp.org)
[7] https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_SEC.pdf (see Chapter 2.)
[8] Davis, M. A., Anthopolos, R., Tootoo, J., Titler, M., Bynum, J. P. W., & Shipman, S. A. (2018). Supply of Healthcare Providers in Relation to County Socioeconomic and Health Status. Journal of General Internal Medicine, 4–6. https://doi.org/10.1007/s11606-017-4287-4.
[9] Xue, Y., Smith, J. A., & Spetz, J. (2019). Primary Care Nurse Practitioners and Physicians in Low-Income and Rural Areas, 2010-2016. Journal of the American Medical Association, 321(1), 102–105.
[10] Andrilla, C. H. A., Patterson, D. G., Moore, T. E., Coulthard, C., & Larson, E. H. (2018). Projected Contributions of Nurse Practitioners and Physicians Assistants to Buprenorphine Treatment Services for Opioid Use Disorder in Rural Areas. Medical Care Research and Review, Epub ahead. https://doi.org/10.1177/1077558718793070
[11] https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/

NPs are also the second largest provider group in the National Health Services Corps[12] and the number of NPs practicing in community health centers has grown significantly over the past decade.[13] When rural communities experience hospital closures, it is often NPs who are filling the gaps and providing critical care to these communities. According to the Government Accountability Office (GAO), an exception to the pattern of clinicians leaving rural areas after rural hospital closures were APRNs, finding that "[c]ounties with rural hospital closures experienced a greater increase in the availability of advanced practice registered nurses (61.3 percent), compared to counties without closures (56.3 percent)."[14]

As Chairman Smith noted in his opening statement, "Congress must help patients who want more control and flexibility over their health care, especially those with chronic conditions or living in rural areas."[15] We also strongly agree that "we cannot accept the same tired approaches that have not made a meaningful difference for enough patients."[16] It is important to note that Congressional action to remove NP barriers has been a catalyst to improving access to care for patients.

For example, after the passage of the *Comprehensive Addiction and Recovery Act of 2016* (CARA), studies found that NPs increased access to medication-assisted treatment in rural and underserved communities. One study found that NPs and PAs were the first waivered providers in hundreds of rural counties, representing millions of individuals.[17] The Medicaid and CHIP Payment and Access Commission also found that the number of NPs prescribing MOUD and the number of patients treated with MOUD by NPs increased substantially in the first year they were authorized to obtain their Drug Addiction and Treatment Act (DATA) waiver, particularly in rural areas and for Medicaid beneficiaries.[18]

In addition, on March 27, 2020 the Federal Coronavirus Aid, Relief, and Economic Security (CARES) Act was signed into law. Section 3708 of the CARES Act permanently authorizes nurse practitioners, clinical nurse specialists, and physician assistants to certify for Medicare and Medicaid home health care services in accordance with state law.[19] Following the passage of this important legislation, over 40 states have taken action to update their statutes and regulations to reflect the federal changes and expand access to home health care services.

As NPs provide a substantial portion of care in rural and underserved communities, it is critical that policies advanced by the Committee include expanding access to NP provided care. Despite their importance to the workforce, there are still federal barriers which inhibit NPs authority to provide care to communities, including to patients in their homes. Included below are our suggested proactive policy solutions, and we greatly appreciate your consideration of this statement.

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[12] https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2024.pdf
[13] https://www.nachc.org/wp-content/uploads/2023/07/Community-Health-Center-Chartbook-2023-2021UDS.pdf
[14] https://www.gao.gov/assets/gao-21-93.pdf
[15] Chairman Smith Opening Statement – Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities - House Committee on Ways and Means
[16] Ibid
[17] https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00859.
[18] https://www.macpac.gov/publication/analysis-of-buprenorphine-prescribing-patterns-among-advanced-practitioners-in-medicaid/.
[19] BILLS-116hr748enr.pdf (congress.gov)

Increase Access by Removing Barriers

Reports issued by the National Academies of Medicine[20], American Enterprise Institute,[21] the Brookings Institution,[22] the Federal Trade Commission[23], the Bipartisan Policy Center[24] and the U.S. Department of Health and Human Services under multiple administrations[25,26,27] have all highlighted the positive impact of removing barriers confronted by NPs and their patients. The World Health Organization's *State of the World's Nursing 2020* report also recommends modernizing regulations to authorize APRNs to practice to the full extent of their education and clinical training, and noted the positive impact this would have on addressing health care disparities and improving health care access within vulnerable communities.[28]

As the Committee works on legislation to enhance access to care at home, we strongly encourage inclusion of the following bipartisan legislation; the *Increasing Access to Quality Cardiac Rehabilitation Care Act of 2023* (H.R. 2583), the *Promoting Access to Diabetic Shoes Act* (H.R.704), and the *Improving Care and Access to Nurses Act* (H.R. 2713). These bipartisan bills will reduce the administrative burden for NPs and increase needed access to care for patients. Federal barriers within the Medicare program which prevent NPs from: ordering cardiac and pulmonary rehabilitation services, certifying the need for therapeutic shoes for patients with diabetes, refer patients for medical nutrition therapy, establishing and reviewing home infusion plans of care for, certifying and recertifying hospice eligibility orders all have a detrimental impact on patient access to care. This is especially true in rural communities, where requiring unnecessary referrals presents immense challenges for patients. Removal of these barriers is critical to enhancing access to care at home in rural and underserved communities.

- ***Improving Care and Access to Nurses (ICAN) Act* (H.R. 2713*)***

HR 2713 would update the Medicare and Medicaid programs to ensure that NPs and other APRNs are authorized to provide care as effectively and efficiently as possible, consistent with state law. This includes updating Medicare and Medicaid to remove barriers to evidence-based preventive services such as authorizing NPs to order cardiac and pulmonary rehabilitation, refer patients for medical nutrition therapy, certify patients' needs for diabetic shoes, establish home infusion plans of care, and perform mandatory visits in skilled nursing facilities. This bill does not supersede any state laws, it simply modernizes these provisions within Medicare and Medicaid to make them consistent with state law to ensure that beneficiaries have access to these health care services, from their provider of choice, without undue burden. This legislation is supported by over 235 national, state, and local organizations[29] including the National Rural Health Association, National Association of Rural Health Clinics, American Health Care Association, LeadingAge, Americans for Prosperity, and AARP.[30] Patients who choose NPs

[20] The Future of Nursing 2020-2030 - National Academy of Medicine (nam.edu)
[21] https://www.aei.org/wp-content/uploads/2018/09/Nurse-practitioners.pdf.
[22] https://www.brookings.edu/wp-content/uploads/2018/06/AM_Web_20190122.pdf.
[23] https://www.aanp.org/advocacy/advocacy-resource/ftc-advocacy.
[24] Strengthening the Health Professional Workforce | Bipartisan Policy Center
[25] https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf
[26] https://aspe.hhs.gov/pdf-report/impact-state-scope-practice-laws-and-other-factors-practice-and-supply-primary-care-nurse-practitioners.
[27] https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/Rural-Strategy-2018.pdf.
[28] https://apps.who.int/iris/bitstream/handle/10665/331673/9789240003293-eng.pdf
[29] https://www.aanp.org/news-feed/more-than-235-organizations-show-their-support-for-the-ican-act.
[30] https://www.aana.com/comment-letter/aarp-endorsement-of-i-can-act-hr-2713.

as their health care providers should not face increased burdens and decreased access to medically necessary treatment that are covered by Medicare and Medicaid.

- ***Promoting Access to Diabetic Shoes Act*** **(H.R. 704)**

HR 704 would authorize NPs s to satisfy the documentation requirement for coverage of certain shoes for individuals with diabetes. NPs provide the full range of care to patients with diabetes, but federal law requires that an NP must send a patient who needs therapeutic shoes to a physician to certify that need. Additionally, according to current statute, the certifying physician must take over the treatment of the patient's diabetic condition going forward. These barriers often lead to delays in accessing needed items and undermine care continuity. The estimated total annual cost of an individual patient with diabetes is $17,000.[31] However, if left untreated, patients with diabetes may face serious complications including foot ulcers or amputations, driving up the estimated annual individual costs to $52,000.[32] By removing this outdated and unnecessary barrier, NPs would be authorized to certify the need for therapeutic shoes for patients with diabetes, and ensure they get the care they need in a timely fashion.

Passage of this legislation will also reduce Medicare spending by eliminating duplicative services. Removing the unnecessary additional certifying visit requirements could save the Medicare program $12.1 million annually.[33] Data also demonstrates that NPs manage the care for patients with diabetes in a cost-effective manner that results in health care savings. A recent study utilizing Veterans Affairs (VA) data from FY 2013 found significant savings, 6-7% lower costs, for highly complex diabetic patients who had an NP as their primary provider compared to those with a physician.[34] Other researchers found even greater savings, 12-13% lower costs when examining patients with diabetes with varying degrees of complexity served by the VA. For a single VA medical center, this equated to an annual savings of just over $14 million, exemplifying the efficiency and effectiveness of NP delivered care in the VA.[35] Patients who choose nurse practitioners as their health care providers deserve equitable access to care from their chosen health care provider.

- ***Increasing Access to Quality Cardiac Rehabilitation Care Act*** **(H.R. 2583)**

HR 2583 would authorize NPs to order cardiac and pulmonary rehabilitation for Medicare patients. In 2018, Congress passed legislation which authorized NPs, clinical nurse specialists (CNSs) and physician assistants (PAs) to supervise cardiac and pulmonary rehabilitation starting in 2024. However, these clinicians are still not authorized to order cardiac and pulmonary rehabilitation for Medicare patients.

Cardiac rehabilitation and pulmonary rehabilitation are programs designed to improve a patient's physical, psychological, and social functioning after a qualifying diagnosis or procedure, such as a heart

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[31] American Diabetes Association. (2018). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care. 41, 917-928. http://care.diabetesjournals.org/content/diacare/early/2018/03/20/dci18-0007.full.pdf

[32] Agency for Healthcare Research and Quality (2011). Data points #3: Economic burden of diabetic foot ulcers and amputations. https://effectivehealthcare.ahrq.gov/topics/diabetes-foot-ulcer-amputation-economics/research

[33] Analysis based on author calculations. Approximately 134,000 Medicare patient visits billed using an established patient level 3 E/M code (CPT 99213).

[34] Morgan, et.al (2019). Impact of Physicians, Nurse Practitioners, And Physician Assistants On Utilization and Costs for Complex Patients. *Health Affairs,* 38(6), 1028-1036. https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00014.

[35] Rajan, et. al (2021) "Health care costs associated with primary care physicians versus nurse practitioners and physician assistants". https://pubmed.ncbi.nlm.nih.gov/34074952/.

attack or coronary artery bypass surgery or after a diagnosis of chronic obstructive pulmonary disease (COPD). Heart disease remains the leading cause of death in the United States with nearly 700,000 deaths per year.[36] Not only does heart disease have a tremendous impact on the lives of patients and their families, but managing and treating heart disease and related risk factors is estimated to cost the United States over $320 billion annually.[37] Chronic obstructive pulmonary disease (COPD) is the sixth leading cause of death in the United States, with nearly 150,000 deaths per year.[38] COPD is estimated to cost the United States nearly $50 billion annually in related health care expenditures and indirect mortality and morbidity costs.[39]

Yet, while studies show that these programs can reduce hospitalizations, decrease heart attack recurrence, increase adherence to preventive medication, improve overall health and reduce the need for costly care, less than 25 percent of qualifying patients receive cardiac rehabilitation and only three percent of Medicare patients with COPD receive pulmonary rehabilitation.[40,41,42] Participation rates are even lower for female and minority patients and those who live outside metropolitan areas or in lower income urban areas.[43],[44] Research also indicates that cardiac rehabilitation is associated with lower all-cause mortality rates in patients with diabetes, however patients with diabetes have lower participation rates than the non-diabetes population.[45] For these reasons, it is essential that Congress increase access to these vital services.

- ***HPSA Bonus Program***

We also strongly encourage the Committee to examine the Health Professional Shortage Area (HPSA) Bonus program and expand the program to include NPs. Currently, Section 1833(m) of the Social Security Act provides 10% bonus payments on Medicare claims for physicians who furnish medical services in geographic areas that are designated by the Health Resources & Services Administration (HRSA) as primary medical care HPSAs.[46] Despite NPs comprising half of Medicare's primary care workforce in rural areas, our members are not eligible for this bonus, leading to significant payment disparities for NPs in primary care, and limiting their ability to provide comprehensive primary care in their communities.

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[36] https://www.cdc.gov/heartdisease/about.htm
[37] Birger M, Kaldjian AS, Roth GA, Moran AE, Dieleman JL, Bellows BK. Spending on Cardiovascular Disease and Cardiovascular Risk Factors in the United States: 1996 to 2016. Circulation. 2021 Jul 27;144(4):271-282. doi: 10.1161/CIRCULATIONAHA.120.053216. Epub 2021 Apr 30. PMID: 33926203; PMCID: PMC8316421.
[38] https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-mortality
[39] https://www.lung.org/research/trends-in-lung-disease/copd-trends-brief/copd-burden
[40] https://millionhearts.hhs.gov/data-reports/factsheets/cardiac.html
[41] https://www.ahajournals.org/doi/10.1161/CIRCOUTCOMES.119.005902
[42] https://www.atsjournals.org/doi/10.1513/AnnalsATS.201805-332OC
[43] Li S, Fonarow GC, Mukamal K, Xu H, Matsouaka RA, Devore AD, Bhatt DL. Sex and Racial Disparities in Cardiac Rehabilitation Referral at Hospital Discharge and Gaps in Long-Term Mortality. J Am Heart Assoc. 2018 Apr 6;7(8):e008088. doi: 10.1161/JAHA.117.008088. PMID: 29626153; PMCID: PMC6015394.
[44] Castellanos LR, Viramontes O, Bains NK, Zepeda IA. Disparities in Cardiac Rehabilitation Among Individuals from Racial and Ethnic Groups and Rural Communities-A Systematic Review. J Racial Ethn Health Disparities. 2019 Feb;6(1):1-11. doi: 10.1007/s40615-018-0478-x. Epub 2018 Mar 13. PMID: 29536369.
[45] https://www.ahajournals.org/doi/10.1161/JAHA.117.006404.
[46] Physician Bonuses | CMS

Permanent Expansion of Increased Telehealth Access

Telehealth has been a vital lifeline throughout the COVID-19 PHE to reach patients who otherwise would not be able to receive care and it will continue to be an essential access tool moving forward. We thank Congress for extending the Medicare telehealth flexibilities through the end of 2024 and urge the permanent adoption of those policies. In a 2020 AANP member survey on the impacts of COVID-19, 76% of nurse practitioners identified federal telehealth waivers as some of the most beneficial flexibilities throughout the COVID-19 PHE.[47] NPs have made a rapid transition to telehealth, with over half of AANP members reporting their practices have adopted, or increased the use of, telehealth and virtual platforms. According to the United States Health Resources and Services Administration (HRSA), there are 4,986 rural primary care HPSAs and 2,157 non-rural primary care HPSAs.[48] Adequate access to providers impacts patients in both rural and non-rural geographic settings. Permanently removing the restrictions that prevent Medicare patients in certain geographic areas from accessing telehealth is increasingly important.

The expanded coverage of certain services throughout the PHE, including audio-only care, have also enabled NPs and other clinicians to reach patients who otherwise may have been unable to receive medically necessary healthcare, particularly in rural and underserved communities and for patients with behavioral health needs. Coverage of audio-only telehealth has been critical for NPs and patients who do not have access to adequate broadband or technological devices capable of synchronous two-way audio video technology. In the survey previously noted, AANP members reported that the three most significant barriers to telehealth adoptions were patient connectivity issues, patient access to technology and the internet and patient comfort with technology.[49] For patients experiencing issues that prohibit them from utilizing synchronous two-way technology, the permanent coverage of audio-only visits will be an important component of telehealth moving forward.

As Congress further considers telehealth legislation, we respectfully request that increased coverage of telehealth removes barriers to care, and that policies intended to maintain program integrity are flexible and do not inadvertently inhibit patient access to care. Important policy changes include the permanent coverage of audio-only services, and removal of geographic and site restrictions for telehealth services for Medicare beneficiaries.

Conclusion

We are deeply appreciative of the Committee's recognition of the need to enhance access to care at home in rural and underserved communities. We thank the Committee for focusing on improving our nation's health care system, and look forward to working with the Committee on solutions that will expand access to care for patients.

[47] Nurse Practitioner COVID-19 Survey (aanp.org)
[48] Shortage Areas (hrsa.gov)
[49] Nurse Practitioner COVID-19 Survey (aanp.org)

Statement for the Record

House Committee on Ways and Means Hearing

"Enhancing Access to Care at Home in Rural and Underserved Communities"

March 12, 2024

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Emily Johnson at ejohnson@bloomhealthcare.com

Members of the U.S. House Committee on Ways and Means, thank you for holding this important hearing. We submit this statement for the record on behalf of the American Academy of Home Care Medicine (www.aahcm.org) to alert the committee about the status of the Independence at Home (IAH) demonstration and to provide suggestions for extension and revitalization of the model, especially to ensure rural and underserved access to home-based primary care.

History of Independence at Home and the Growing Need for Home-Based Primary Care
For Medicare, home-based primary care brings multiple rewards – enhancing quality of service and access to care for our nation's most ill elders and their families while achieving the important side effect of cost savings for Medicare. The Independence at Home (IAH) demonstration under the Centers for Medicare and Medicaid Services Innovation Center (CMMI) began in 2012 as first authorized by Section 3024 of the Affordable Care Act. Since its inception the demonstration received strong bipartisan support and was extended three times by Congress in the last decade, though never expanded to bring in additional practices.

Under the demonstration, health care providers are rewarded for providing high quality home-based primary care (HBPC) while reducing costs. Focused on care for Medicare patients who have multiple chronic conditions and disability, the IAH model uses mobile interdisciplinary teams of medical and social service professionals to care for patients in their homes, delivering high quality clinical care, excellent patient experience, and significantly lower costs for the Medicare program.

The demonstration was rooted in the reality that high-need Medicare beneficiaries account for a disproportionate share of health care spending. The IAH demonstration used simple criteria, apparent to a clinician seeing a patient, yet also attributable through claims, to identify this group:

- Have two or more chronic conditions, expected to persist for more than a year.
- Have coverage from fee-for-serve Medicare A and B.
- Needs personal assistance with 2 or more activities of daily living such as bathing, dressing.
- Had a non-elective hospital admission in the last 12 months.
- Received Medicare Part A post-acute skilled services in the last 12 months.

At the start of the demonstration, such individuals represented 6% of the Traditional Medicare population but accounted for 30% of Traditional Medicare spending. Today, those qualified for IAH represent nearly 11% of the Traditional Medicare population and account for 44% of Traditional Medicare spending. The number of Traditional Medicare beneficiaries who would qualify for Independence at Home has increased by over 1.2 million since the start of the demonstration, but the number receiving home based primary care has increased by less than 300,000. There are nearly 2 million more seniors who could be benefitting from home-based primary care as delivered by the IAH model but are not currently receiving these services. This number will only grow as the population continues to age, with the first Baby Boomers turning 80 in 2026.

The growing number of seniors in need of home-based primary care, the insufficient supply of home-based primary care providers, particularly in rural and underserved areas, and the increasing share of Medicare costs associated with high need patients all require an effective program that can meet the needs of such patients.

Independence at Home Model Works for Patients, Families, Communities, and Providers

Patients, Families, and Communities

Many older adults living with severe chronic illnesses and disability have trouble traveling to the doctor's office, forcing them to rely on the emergency department or hospital due to cognitive, physical, or social barriers. Homebound seniors are more likely to be socially and economically disadvantaged, and are often socially isolated, with unmet care needs. For seriously ill elders, providing 24/7 medical and social services at home allows them to live a life with dignity and respect, where they want to be...at home. It brings peace of mind to family caregivers by coordinating all needed health services, prepares patients and families for managing serious illness, and supports them until the last day of life.

IAH practices can deliver many services available in an urgent care center or hospital room – portable diagnostic, therapeutic, and monitoring technologies that allow the patient to stay at home, rather than come to the hospital. These services include urgent medical visits, blood tests, X-rays, EKGs, IV medications, oxygen, social work, and caregiver education. By providing such services, elders and families gain access to skilled primary care, maximize their time at home, call 911 less often, and are admitted less often to the hospital. For providers and health systems, the practice of house calls is an old idea, improved with modern technology. By visiting the home, providers build close relationships and trust with patients and families, leading to more accurate diagnosis and more effective treatment.

Through receipt of high-quality care at home, IAH patients experience better quality outcomes. IAH providers are measured on six quality metrics, including all-cause hospital readmissions, ambulatory sensitive hospital admissions, and emergency department visits. In Year 8 of the demonstration, the median participant reduced readmissions by 23%, hospital admissions by 41%, and ED visits by 31%. These remarkable reductions in healthcare utilization translate into what matters most to patients: more time at home, less time cycling in and out of healthcare facilities.

Providers

IAH was designed to bring home based primary care practices into value-based care, with adequate resources to field the mobile teams these patients require. IAH providers serve as the "quarterback" of a mobile team, coordinating medical care and social services that are often as important as medical treatment. These mobile teams of Physicians, Nurse Practitioners or Physician Assistants, and Social Workers address routine and urgent issues and manage nearly all needed care in the home. IAH also encourages innovation in telehealth services. For example, some IAH sites have implemented tele-video after-hours or used specially trained paramedics to keep patients at home and out of the hospital. Many of these services are not reimbursed by Traditional Medicare or are reimbursed at rates well below the cost to provide them.

The IAH model allows health care providers to achieve the following goals.

- Spend more time with their patients.
- Perform assessments in a patient's home environment.
- Assume greater accountability for all aspects of a patient's care.
- Prevent chronic conditions from getting worse.
- Avoid unnecessary emergency department visits and hospitalizations.
- Improve patient and caregiver satisfaction.
- Lower overall costs to Medicare.

The field of home-based primary care overwhelmingly consists of small practices: only 8% of practices have more than 750 patients. Of the over 2,400 home-based primary care practices in 2021, 2,200 of them had fewer than 500 patients. These practices are small businesses that serve a critical role, providing high quality healthcare jobs in their local communities. Delivering equivalent quality of care than larger practices, small practices are also more likely (19% higher) to be in underserved areas – the Area Deprivation Index, a composite metric of how socially disadvantaged a geographic area is.

How the IAH Demonstration Functioned

According to CMS's independent model evaluation, over the 8 years for which results are available, IAH practices have delivered care at $229 million less than expected, or an average of $3,100 per beneficiary per year less than expected.[1] These cost reductions have generated $148 million in net savings for CMS. Participants have generated savings in every single year of the model. IAH practices have also reduced hospitalizations 20% and increased the time that patients spend at home by 13%. Patients of IAH practices have a 40% lower risk of entering a nursing home long term.

Participants also showed signs of improvement throughout the duration of the model. In the first year, 12 of the 17 practices delivered care at costs less than expected, while by Year 5 all practices were delivering care at lower than expected costs. Practices that were not initially delivering lower costs improved to a point where they were saving $330 per beneficiary per month. Practices that were already delivering low-cost care at the start of the model increased the savings they delivered from $400 per beneficiary per month initially to over $700 per beneficiary per month in Year 8.

The IAH demonstration successfully enrolled high need patients, who cost on average $40-$50,000 per year, throughout its 10 years of operation. IAH was initially capped at only 10,000 beneficiaries and never allowed new practices to join after the start of the model. Despite these limitations, the demonstration retained over 80% of its original participating practices through Year 5. Through Year 5, IAH participants saved an average of $2,800 per beneficiary per year, for an average savings rate of 6%.

After Year 5, some practices moved from IAH to other value-based models that offered better cash flow to maintain operations. In the original IAH design, practices would wait 18-24 months to receive any shared savings. Despite newer CMMI models that could accommodate home-based primary care practices, such as CPC+ and Primary Care First, nearly 60% of the IAH practices remained in the demonstration through Year 7 because the primary care models didn't provide sufficient resources for high need patient care. Over the last 2 years of the demonstration, the remaining IAH practices have migrated to the High Needs Direct Contracting/High Needs ACO REACH model, while still delivering high value care. Unfortunately, the High Needs program excludes nearly a quarter of IAH qualified beneficiaries, has a minimum size requirement that excludes 96% of home-based primary care practices, and requires a level of down-side risk that few primary care practices can accept. High Needs ACO REACH is only an option for either the largest

[1] CMS uses a difference-in-difference methodology to calculate savings generated by the model. Under this methodology, the total savings over 8 years has been $117 million, or $201 per beneficiary per month. However, this approach does not account for the lower costs that IAH participants were already generating before they started the model. Adjusting CMS's methodology to account for these lower costs pre-model produces the $229 million savings estimate.

home-based primary care practices or practices that are willing to use a third-party aggregator, which typically takes a large portion of any savings earned.

Apply Lessons Learned to Improve, Expand Independence at Home Model
IAH could benefit nearly two million more Medicare beneficiaries with multiple chronic conditions and disability, the fastest growing and most costly segment of the Medicare population. IAH pays for itself from savings to the Medicare program through a smarter use of resources, providing monitoring and maintenance therapy and using technologically enhanced urgent care services in the home. IAH also eases the overwhelming demand from those living with severe chronic illness and disability, who wish to avoid institutionalization.

The Independence at Home model has benefited from over a decade of experience, including lessons learned from other value-based systems. See Exhibit 1 at end summarizing the many studies and analyses of the Independence at Home model.

With a revitalization of the model, IAH could address the **significant disparities** in who has access to home-based primary care in their community today. The current supply of home-based primary care is concentrated in urban metropolitan areas. According to one study, rural residents were 78% less likely to receive home-based care than residents of the largest metropolitan county.[2]

We humbly ask the committee to not waste the precious resources devoted to this program over the last decade and to capitalize on the promise for IAH's future, especially given the growing need for home-based primary care in the aging Medicare population. We ask that you work with us and Representatives Burgess and Dingell to extend (H.R.6794) and revitalize the model in a few modest ways to ensure that it can continue to serve our nation's elderly:

- Allow a participating home-based primary care practice's full Medicare patient panel to be in an accountable care relationship.
- Remove the arbitrary limit on beneficiaries and practices that inhibits access to care.
- Provide an upfront, monthly, enhanced primary care payment to support complex, high needs care so that participants can make critical care investments immediately, instead of having to wait 18-24 months for shared savings payments.
- Incorporate lessons learned from High Needs ACO REACH around beneficiary alignment methodologies and high needs criteria.
- Introduce additional tools like data sharing and benefit enhancements to help participants better manage care.

Thank you for your committee's focus on home care for our nation's seniors. Providers and allies of the American Academy of Home Care stand with you and commit to assisting you in the laudable goal of best serving our nation's seniors.

For further information, contact Peggy Tighe at Peggy.Tighe@PowersLaw.com or Emily Johnson at ejohnson@bloomhealthcare.com.

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[2] Yao N, Richie C, Cornwall T and Leff B. Use of Home-Based Medical Care and Disparities. Journal of the American Geriatrics Society. 07 August 2018.

Exhibit 1: The Independence at Home Demonstration, A Table Review of the Literature

Title	Authors	Publication/Link	Year
Laying the Groundwork for Independence at Home			
Effects of Home-Based Primary Care on Medicare Costs in High-Risk Elders	Eric De Jonge et al.	62 J. Am. Geriatrics Soc'y	2014
Better Access, Quality, and Cost for Clinically Complex Veterans with Home-Based Primary Care	Thomas Edes et al.	62 J. Am. Geriatrics Soc'y	2014
Geriatric Care Management for Low-Income Seniors: A Randomized Controlled Trial	Steven R. Counsell, Christopher M. Callahan, Daniel O. Clark et al.	298 JAMA	2007
Analysis of Independence at Home Results			
Independence at Home: After 10 Years of Evidence, It's Time for a Permanent Medicare Program	Konstantinos E. Deligiannidis, Peter Boling, George Taler, Bruce Leff, & Bruce Kinosian	71 J. Am. Geriatrics Soc'y	2023
Evaluation of the Independence at Home Demonstration: An Examination of Year 7, the First Year of the COVID-19 Pandemic	Laura Kimmey, Jason Rotter, Joseph Lovins, & Rachel Kogan	Mathematica	2023
Letter to the Editor: Independence at Home Evaluation Findings Do Not Support Creating a Permanent Medicare Program	Laura Kimmey & Jason Rotter	72 J. Am. Geriatrics Soc'y	2023
Reply to: Independence at Home Evaluation Findings Do Not Support Creating a Permanent Medicare Program—It Does	Konstantinos E. Deligiannidis et al.	72 J. Am. Geriatrics Soc'y	2023
The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Katherine Ornstein, David M. Levine, & Bruce Leff	69 J. Am. Geriatrics Soc'y	2021
Comment on: The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Laura Kimmey & Valerie Cheh	70 J. Am. Geriatrics Soc'y	2022
Reply to: Comment on: The Underappreciated Success of Home-Based Primary Care: Next Steps for CMS' Independence at Home	Katherine Ornstein, David M. Levine, & Bruce Leff	70 J. Am. Geriatrics Soc'y	2022
Integrated Home- and Community-Based Services Improve Community Survival Among Independence at Home Medicare Beneficiaries Without Increasing Medicaid Costs	Girish Valluru et al.	67 J. Am. Geriatrics Soc'y	2019
Randomized Controlled Trials			
Outcomes of Home-Based Primary Care for Homebound Older Adults: A Randomized Clinical Trial	Alex D. Federman et al.	71 J. Am. Geriatrics Soc'y	2022
Editorial: The Challenge of Proving the Value of Medical Care in the Home	Peter A. Boling & Bruce Kinosian	71 J. Am. Geriatrics Soc'y	2022
Expanding Independence at Home: Model Projection Papers			
Home-Based Primary Care: Beyond Extension of the Independence at Home Demonstration	James Rotenberg et al.	66 J. Am. Geriatrics Soc'y	2018

Projected Savings and Workforce Transformation from Converting Independence at Home to a Medicare Benefit	Bruce Kinosian, George Taler, & Peter Boling	64 J. Am. Geriatrics Soc'y	2016
Targeting Frail High Cost Veterans Improves Impact And Efficiency Of Home Based Primary Care (HBPC)	T.E. Edes et al.	1 Innovation in Aging	2017
To Strengthen the Primary Care First Model for the Most Frail, Look to the Independence at Home Demonstration	Bruce Leff, Peter Boling, George Taler, & Bruce Kinosian	Health Affairs Blog	2020
Home-Based Care Systematic Reviews of Outcomes			
Systematic Review of Outcomes from Home-Based Primary Care Programs for Homebound Older Adults	Nathan Stall, Mark Nowaczynski, & Samir K. Sinha	62 J. Am. Geriatrics Soc'y	2014
Comparative Effectiveness Review No. 164: Home Based Primary Care Interventions	Agency for Healthcare Rsch. and Quality, U.S. Dep't of Health and Hum. Servs.	AHRQ	2016
Home-Based Primary Care: A Systematic Review of the Literature, 2010-2020	Robert M. Zimbroff, Katherine A. Ornstein, & Orla C. Sheehan	69 J. Am. Geriatrics Soc'y	2021
Continuing Need for and Disparities in Access to Home-Based Care			
Primary Care in the Home: The Independence at Home Demonstration in Primary Care for Older Adults	George Taler, Peter Boling, & Bruce Kinosian	Primary Care for Older Adults	2018
Use of Home-Based Clinical Care and Long-Term Services and Supports Among Homebound Older Adults	Jennifer M. Reckrey et al.	24 J. Am. Medical Directors Association	2023
Geographic Concentration of Home-Based Medical Care Providers	Nengliang Yao et al.	35 Health Affairs	2016
Home-Based Medical Care Use in Medicare Advantage and Traditional Medicare in 2018	Jeffrey Marr et al.	42 Health Affairs	2023
County-Level Social Vulnerability, Metropolitan Status, and Availability of Home Health Services	Harriet Mather, Katherine A. Ornstein, & Catherine McDonough	JAMA Open Network	2023
The Dynamics of Being Homebound Over Time: A Prospective Study of Medicare Beneficiaries	Claire K. Ankuda et al.	69 J. Am. Geriatrics Soc'y	2021

Subject: Enhancing Access to Care at Home in Rural and Underserved Communities

To: U.S. House Ways and Means Committee, WMSubmission@mail.house.gov

Our organization, Recora, writes to express support for increasing virtual care that facilitates care at home, especially in rural and underserved communities. There is a plethora of data to support that virtual access to cardiac and pulmonary rehabilitation services can:

- Improve clinical outcomes
- Reduce costs via fewer hospitalizations and emergency room visits
- Address health inequities and barriers to care

Cardiac and pulmonary rehabilitation are valuable services that have suffered access shortages, especially among rural and underserved communities. Cardiac rehabilitation has been identified as a high-value standard of care supported by both CMS and the CDC. These agencies, through the Million Hearts Initiative, have set a 70% participation goal for cardiac rehabilitation, but only 1 in 4 starts a program, with ultimately only 8% completing a program.

Virtual cardiac and pulmonary rehabilitation reduce several barriers faced by rural and underserved communities, including geographical distance, transportation limitations, and shortage of healthcare providers. By leveraging technology to deliver rehabilitation services remotely, patients can receive timely care without the need to travel long distances, which can be particularly burdensome for individuals with cardiovascular or pulmonary conditions. In fact, many Americans live in "Cardiac Rehabilitation Deserts" (referenced below) - where it is impossible to access these services without a virtual option.

Multiple studies, including a recent study by the Veterans Administration, have demonstrated mortality (36% reduction over 4.2 years) and hospitalization reduction benefits with access to virtual cardiac rehabilitation. With improved access, patients adhere to their rehabilitation regimens, leading to better health outcomes and reduced hospital readmissions.

Virtual rehabilitation also optimizes resource allocation and delivers more cost-effective care. By reducing the need for in-person visits and streamlining administrative processes, healthcare facilities can allocate their resources more efficiently, reach a larger patient population, and focus on delivering high-quality, evidence-based care. This not only enhances the sustainability of healthcare systems but also ensures that limited resources are allocated equitably across different communities.

As the U.S. continues to navigate the complexities of healthcare delivery, especially in rural and underserved areas, it is imperative that we embrace data-driven solutions to bridge the gaps in access and improve health outcomes for all individuals, regardless of their geographical location or socioeconomic status.

We urge the Ways and Means Committee to support policies and legislation (e.g., H.R. 1406) that would protect access to programs such as virtual cardiac and pulmonary rehabilitation, ensuring that every patient has access to this cost-saving standard of care when and where they need it.

Please see the below facts and links (Exhibit 1) to studies that demonstrate the positive results of these virtual programs. In addition, please see attached a letter (Exhibit 2) that was sent by a coalition of hospitals and organizations to House and Senate leads of H.R. 1406 and S. 3021, demonstrating broad support on the issue.

Exhibit 1. Key Facts

- Hundreds of thousands of Medicare beneficiaries are at risk of completely **losing access to virtual cardiac and pulmonary rehabilitation** — proven and standard methods of keeping people alive and out of the hospital — and this can't be restored unless Congress takes action.
- During the public health emergency, **patients with heart and lung conditions were allowed to complete their rehab programs from home** rather than traveling to a hospital or doctor's office 36 times over three months.
- **Bipartisan legislation (H.R. 1406):** Reps. John Joyce (R-PA) & Scott Peters (D-CA) have introduced legislation that protects access to virtual rehabilitation - a standard of care that decreases hospitalizations by ~30%.

Cardiac Rehabilitation

- Every year, more than a million Americans have heart attacks, bypass surgery, or other events that make them candidates for cardiac rehab.
- After a heart attack or heart surgery, **completing cardiac rehab can increase life expectancy by up to five years** and **reduce hospitalizations by 30%**.
    - Cardiac rehab is a three-month program focused on exercise, diet, and counseling by a combination of providers, including physicians, therapists, nutritionists, and counselors.
- **Not enough people complete cardiac rehab** – 90 percent of patients don't complete their in-person cardiac rehab programs, partly because commuting to a hospital twice a week for three months can be challenging.
- **Limited access to in-person cardiac rehab is a problem.** Many Americans live in "cardiac rehab deserts," far away from the nearest facility in both urban and rural areas.

Pulmonary Rehabilitation

- Chronic obstructive pulmonary disease (COPD) affects millions of Americans and is one of the leading causes of death.
- **COPD rates are higher in rural areas** (8 percent) than in urban areas (5 percent), contributing to the access gap in pulmonary rehabilitation.
- Pulmonary rehabilitation is cost effective, reduces hospitalizations, and improves quality of life.
- Virtual programs have demonstrated better access and similar outcomes to facility programs.

Virtual Cardiac / Pulmonary Rehabilitation

- **Virtual rehabilitation has already ended due to a reimbursement issue (when provided by a hospital), and the last remaining office-provided virtual rehabilitation ends completely in 2024.**
    - Unlike many other types of virtual care – such as behavioral health and maternal health treatment – virtual cardiac and pulmonary rehabilitation for hospitals was not extended in previous telehealth legislation passed by Congress.
- **The PHE proved that virtual rehabilitation works – reducing death rates by 36 percent.**
    - Just like in-person rehab, these virtual programs are supervised in real-time by licensed providers – but they use live video calls rather than requiring patients to travel.
    - Virtual cardiac rehab has reduced hospitalizations and is as effective as in-person.
- There are guardrails for Virtual Cardiac / Pulmonary Rehabilitation
    - **Services focused**: there is no prescribing of medications or devices during these programs, resulting in no add-on costs related to prescribed items.

- CMS has requirements on care plans, duration, and supervision for these services.
- OIG recently released a report that documented telehealth services have been compliant with Medicare regulations and are at no higher risk for fraud and abuse.

Impact on Health Disparities

- Women are 13% less likely to complete CR, further complicating their 2X likelihood of fatal heart attacks, compared with men.
- Blacks and Hispanic individuals are 30+% less likely to participate in CR
- **Data show that virtual rehab reduces health care disparities** - 11% more women, 22% more Blacks, and 230% more Hispanic populations use Virtual CR

Legislation on Virtual Cardiac and Pulmonary Rehabilitation

- **H.R. 1406** by Reps. John Joyce (R-PA) and Scott Peters (D-CA) has 50+ bipartisan cosponsors.
- **The legislation restores the policies in place** that allowed Medicare beneficiaries to access virtual cardiac and pulmonary rehabilitation.

Broad Support for Restoring Virtual Cardiac and Pulmonary Rehabilitation

- **Patient and provider groups:**
  - American Association of Cardiovascular and Pulmonary Rehabilitation
  - COPD Foundation
  - American Association for Respiratory Care
  - American College of Chest Physicians
  - American College of Cardiology
  - American Thoracic Society
  - American Telemedicine Association
  - Alliance for Connected Care

Exhibit 2. Coalition Letter Sent to H.R. 1406 and S. 3021 Co-leads

The Honorable Kyrsten Sinema
United States Senate
Washington D.C. 20510

The Honorable Marsha Blackburn
United States Senate
Washington, DC 20510

The Honorable Amy Klobuchar
United States Senate
Washington, DC 20510

The Honorable John Joyce
U.S. House of Representatives
Washington, DC 20515

The Honorable Scott Peters
U.S. House of Representatives
Washington, DC 20515

November 13, 2023

Dear Senator Sinema, Senator Blackburn, Senator Klobuchar, Rep. Joyce, and Rep. Peters:

We write to express our strong support for bipartisan legislation currently under consideration in the Senate and House of Representatives to restore and protect access to virtual cardiac and pulmonary rehabilitation for hundreds of thousands of Medicare beneficiaries across the country. The legislation — S. 3021, introduced by Senators Kyrsten Sinema, Marsha Blackburn, and Amy Klobuchar, and H.R. 1406, introduced by Representatives John Joyce and Scott Peters — would reinstate policies that lapsed in May 2023 with the end of the public health emergency and once again allow patients to complete cardiac and pulmonary rehabilitation programs from home without having to travel to a hospital or doctor's office. Thank you for taking the leadership on this very important issue which impacts many Medicare beneficiaries.

Nearly half of Americans have some form of cardiovascular disease. After a heart attack or heart surgery, completing cardiac rehabilitation can increase life expectancy by up to five years and has been shown to significantly reduce rehospitalizations. However, only one in four Medicare patients even start cardiac rehabilitation, and 90 percent of people don't end up completing their in-person rehabilitation programs, in part because they have traditionally required patients to commute to a hospital or doctor's office 36 times over a three-month period.

Chronic obstructive pulmonary disease, or COPD, affects millions of Americans and is one of the leading causes of death, with higher rates in rural areas (8%) than in urban areas (5%), contributing to the access gap in pulmonary rehabilitation. Pulmonary rehabilitation programs reduce hospitalizations and improve patient quality of life.

During the public health emergency, virtual cardiac and pulmonary rehabilitation became broadly available. The Hospital Without Walls waiver allowed rehabilitation departments operated by hospitals to deploy virtual programs, in which patients were supervised in real-time by providers using video communications on computers or mobile devices.

Data has shown that virtual cardiac rehabilitation is effective, reducing death rates by 36 percent as compared to patients who did not complete their program. Virtual cardiac rehab patients experience

lower readmission rates. Pulmonary virtual programs have also demonstrated better access and similar outcomes to facility programs.

The availability of virtual cardiac and pulmonary rehabilitation was a significant step forward in eliminating barriers that have prevented patients from starting or completing traditional rehab programs. Many Medicare beneficiaries live in "rehabilitation deserts" — rural, suburban, and even urban communities in which in-person rehab facilities are either too few or too far away. For patients with mobility challenges, jobs with limited time off, or who depend upon public transportation, traveling twice a week for three months is not a viable option. Studies have found that women and members of minority groups are less likely to complete cardiac or pulmonary rehabilitation. In situations where patients have language or cultural barriers that make it difficult to participate in a program at a nearby facility, virtual rehabilitation allows them to work with appropriate providers anywhere in the country.

Expanding access lowers healthcare spending. According to data released by the Department of Health and Human Services' Million Hearts initiative, when patients complete all 36 sessions of cardiac rehabilitation, it saves between $4,950 and $9,200 per person per year of life saved.

S. 3021 and H.R. 1406 would restore the provisions relating to virtual cardiac and pulmonary rehabilitation that were in place under the public health emergency. Specifically, these bills would reauthorize the hospital-based virtual rehabilitation programs that served 95 percent of patients prior to the end of the emergency, and they would also ensure that virtual programs operated out of individual providers' offices are allowed to continue.

Cardiac and pulmonary rehabilitation are proven interventions that keep patients alive longer and out of the hospital, and as a result of the public health emergency, we also know that virtual forms of these programs are an effective way to increase access for patients across the country. On behalf of the hundreds of thousands of Medicare patients who would immediately benefit — and the millions more who will likely need it in the future.

We thank you for your leadership and urge you to pass this legislation so that we can restore and protect access to virtual cardiac and pulmonary rehabilitation.

Sincerely,

Patient and provider groups:

- American Association of Cardiovascular and Pulmonary Rehabilitation
- American Association for Respiratory Care
- American College of Chest Physicians
- American College of Cardiology
- American Thoracic Society
- COPD Foundation

Health systems:

- Community Health Systems (AL, AK, AZ, AR, FL, GA, IN, MO, MS, NM, NC, OK, PA, TN, TX)

- Advocate Health (AL, GA, IL, NC, SC, WI)
- Ballad Health (TN, VA, NC, KY)
- Mass General Brigham (MA, NH, ME)
- ProMedica (OH, MI, PA)
- Baptist Health (IN, KY)
- Geisinger Health System (PA, DE, ME)
- Bassett Healthcare Network (NY)
- ColumbiaDoctors (NY)
- Nuvance Health (NY)
- Tampa General Hospital (FL)
- Lakeland Regional Health (FL)
- Lee Health (FL)
- Marshall Medical Center (CA)
- Davis Medical Center (WV)
- Arkansas Heart Hospital (AR)
- Cardiovascular Institute of the South (LA)
- University Medical Center Health System (TX)
- Benson-Henry Institute at Massachusetts General Hospital (MA)
- Adventist HealthCare (MD)
- Ascension St. Thomas (TN)
- Nevada Heart and Vascular Center (NV)
- Renown Health System (NV)
- EvergreenHealth (WA)

Industry organizations:

- Recora Health
- Pritikin ICR
- Ornish Lifestyle Medicine
- Chanl Health
- Carda Health

Statement for the Record
Submitted to U.S. House Committee on Ways and Means
"Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities"
Tuesday, Marcg 12, 2024
By: Michael C. Markowicz, General Counsel

Background

Approximately 37 million patients suffer from chronic kidney disease and 726,000 have end-stage renal disease (ESRD). Patients with chronic kidney disease may experience fragmented care and high-cost treatments that do little to slow disease progression. They also receive limited to no education about their disease and treatment options. ESRD treatment accounts for over 7% in Medicare spend, but only 1% of Medicare beneficiaries have ESRD.

Approximately 37 million patients suffer from chronic kidney disease and 726,000 have kidney failure, knowns as end-stage renal disease or "ESRD." Treatment of kidney failure accounts for over 7% in Medicare spend, but only 1% of Medicare patients have ESRD.

Impact on Rural Americans

The challenges these patients face are significantly worse in rural areas, where studies show reduced access to kidney transplantation, home dialysis training, and renal replacement therapy in less-populated areas. Because patients have less access to health services, they may need to travel up to 75 miles to see a nephrologist or receive dialysis. This disproportionate burden on kidney patients in rural communities is a prime example of how geography can contribute to inequalities in healthcare treatment, quality of life, and life expectancy.

About Evergreen Nephrology

Evergreen Nephrology (Evergreen) partners with nephrologists to create an improved experience for people living with chronic kidney disease. Our nephrologist-led model establishes value-based enterprises with nephrology practices, whereby nephrologists are empowered to improve the overall quality and reduce the total cost of care for their patients with late-stage, chronic kidney disease and end-stage kidney disease. Through a coordinated care model, Evergreen and our nephrologist partners delivery interdisciplinary clinical resources, analytical insight and tools, and services to our most vulnerable patients. Successfully transforming kidney care requires our nephrology partners and us to identify and address our patients' overall health and need, including the serious comorbidities that nearly all these individuals face. Increasing access to care and care management, including through telemedicine and providing care in the home, is a key tenet of our nephrologist-led model.

CMS Kidney Model

To improve care for kidney patients the Centers for Medicare & Medicaid Services (CMS) launched a kidney care focused model in 2019. The kidney care model rewards nephrologists who invest in delivering care to their patients proactively by shifting from a fee-for-service Medicare reimbursement mechanism to one where nephrologists capture savings from lower medical spending while improving quality.

Nephrologists caring for 40% of original Medicare patients on dialysis chose to participate in the model. The high participation was due to both the model empowering nephrologists to drive better health outcomes for patients, and the lack of a viable path forward for nephrologists in fee-for-service Medicare.

In the model CMS provides nephrologists a "benchmark" or baseline funding number that is the government's projection for what should be spent on the care for nephrologists' patients in a given year. The nephrologists then make investments in services and staff to improve care and outcomes for patients during the year, all the while measuring their work against that "benchmark". The nephrologists benefit because they capture savings from lower medical spending while improving quality for patients.

Evergreen and Participant Nephrologist Impact

Evergreen has 700+ partnered providers across 17 states, of which 440+ Evergreen providers in 10 states participate in the kidney model. These providers serve nearly 17,700 patients who are covered by original Medicare and who benefit from the comprehensive care afforded by the model.

Evergreen is delivering excellent outcomes for patients in the model:

- **Optimal starts on dialysis**: 59%, compared with the Medicare eligible rate of 26.5% and CMS's target (90th percentile) of 50%. The organization's achievement here puts it into the CMS high-performer pool.
- **Depression screening (PHQ-9) completion:** 74%, compared with the CKCC target of 50%. By looking out for behavioral health needs of kidney patients and referring to behavioral health specialists where needed, Evergreen and its partners drive better holistic health outcomes for patients.
- **Patient Activation Measure (PAM) change score:** 7.5, compared with CMS target of 3. PAM is an industry measure of patient engagement, in which higher scores indicate greater levels of patient and family engagement in their care. An increase of at least 3 points is associated with the patient and their family achieving better outcomes due to better understanding and being more personally engaged with their care.

These outcomes measures add up to more days that patients spend healthy and at home.

The Retrospective Trend Adjustment Issue

CMS made a recent decision to apply a retrospective adjustment to the "benchmark" because they did not predict the number correctly for program year 2022 and 2023. This means that funding for the patients is reduced after the care has already been provided.

An example of how this works for illustrative purposes is below:

- CMS gives Nephrology Group their proposed benchmark of $10 million in 2022, which means CMS projects the nephrologists will spend $10 million providing care to their kidney patients.
- In 2022 Nephrology Group invests in more staff and services to provide better care to their kidney patients. They improve outcomes for those patients and save money. In the end, the Nephrology Group only spends $9 million on better care for their patients in 2022.
- In November 2023, CMS told Nephrology Group they predicted their 2022 spend incorrectly and they will be applying the retrospective trend adjustment which makes the new benchmark $8 million for 2022. This means that 11 months after the program year ended the Nephrology Group

goes from saving $1 million to increasing costs for patients by $1 million. This impacts their bottom line since they capture savings after CMS gets its guaranteed taxpayer savings.

The retrospective adjustment provides no predictability or stability to nephrologists. You cannot operate a business knowing that a year after you provided the services the government is going to move the goal post. It discourages further investments by nephrology groups to improve care to these patients, which was the goal of the model.

CMS Response

CMS acknowledged the flaws in making retroactive changes. To improve model predictability, starting in 2024, CMS adjusted their approach for the kidney model by instituting "risk corridors," or caps on the impact of the retrospective trend adjustment. Unfortunately, they are not correcting the impact on 2022 and 2023. This leaves nephrologists with difficult choices to make up for the funding loss. They have been forced to reduce staff that provide support to patients and will hurt their ability to improve care.

Recommendation and Conclusion

Evergreen commends the Committee for holding this hearing to promote and enhance access to care, particularly care in the home, for rural and underserved communities. This need is particularly acute for rural Americans with chronic kidney disease and end-stage renal disease. The CMS kidney model, Comprehensive Kidney Care Contracting (CKCC), has the potential to be transformative for the rural Americans aligned to the model.

Evergreen Nephrology respectfully requests that the Committee and its Members ask CMS about the "retrospective trend adjustment" in the CKCC kidney program and urge CMS, in making a decision on this issue, to consider the potential impact to access to care for rural Americans with kidney disease.

Among the questions that should be asked of CMS, we would respectfully recommend the following:

1. Did CMS consider the impact on Medicare beneficiaries in rural areas when deciding whether to exercise its discretion to not apply a retrospective adjustment to the Kidney Program for 2022 and 2023?

2. Did CMS explore reasons for why the retrospective adjustment might be uniquely damaging to patients with kidney disease in rural areas, especially with regard to opportunities for preemptive kidney transplants, home dialysis and other forms of home healthcare?

3. Have any Kidney Model participants who serve patients in rural areas departed the Kidney Program following 2023?

4. Have any such Kidney Model participants expressed that they are considering leaving the program in advance of the April 30th deadline for 2024, but have not yet done so?

5. In response to the retrospective adjustment, have any Kidney Model participants communicated that they will scale back their investments in supporting patients, particularly rural patients or with regard to home visits?

6. Will CMS consider eliminating or reducing the retrospective adjustment in the Kidney Program for 2022 and 2023?

March 12, 2024

The Honorable Jason Smith
Chairman
Committee on Ways and Means
U.S. House of Representatives
1139 Longworth HOB
Washington, DC 20215

The Honorable Richard Neal
Ranking Member
Committee on Ways and Means
U.S. House of Representatives
1129 Longworth HOB
Washington, DC 20215

Re: MGMA Statement for the Record – House Committee on Ways and Means' Hearing, "Enhancing Access to Care at Home in Rural and Underserved Communities"

Dear Chairman Smith and Ranking Member Neal:

The Medical Group Management Association (MGMA) thanks you for holding this important hearing examining ways to enhance access to home care for patients in rural and underserved communities. Telehealth services provide a vital lifeline to patients in their homes across the nation and ensure continuity of care no matter where they may be located. We appreciate your leadership in holding this important hearing to discuss ways to bolster home care — permanently instituting many of the telehealth policies currently in place would help accomplish this goal.

With a membership of more than 60,000 medical practice administrators, executives, and leaders, MGMA represents more than 15,000 group medical practices ranging from small private medical practices to large national health systems, representing more than 350,000 physicians. MGMA's diverse membership uniquely situates us to offer the following policy recommendations.

Patients in rural and underserved areas have been able to receive high-quality care in their home through the expansion of telehealth services over the past few years. Maintaining access to these vital services is essential to augment in-person care and ensure patients do not face unnecessary barriers such as having to travel significant distances to receive necessary medical care. The Centers for Medicare and Medicaid Services (CMS) instituted numerous temporary telehealth polices in response to the COVID-19 pandemic. Prior to these policies, telehealth services in Medicare were rarely used given geographic, originating site, and other restrictions. This expansion has been a demonstrable success and allowed medical groups to continue serving their communities through the appropriate utilization of telehealth services.

Congress thankfully passed the *Consolidated Appropriations Act of 2023* to extend many of these flexibilities through the end of calendar year 2024. It is imperative to build on this legislation, not allow these flexibilities to expire, and make permanent these policies as the utility of telehealth to patients has been widely established.

MGMA's 2024 priorities for telehealth are as follows:

- Expand access to telehealth services under the Medicare program by permanently removing current geographic and originating site restrictions.
- Permanently cover and reimburse audio-only visits at a rate that adequately covers the cost of delivering that care.
- Appropriately reimburse medical practices for telehealth services to allow them to provide cost-effective, high-quality care.
- Support improving coverage of telehealth by removing administratively burdensome billing requirements, such as collecting patient co-pays for virtual check-ins.
- Ensure continuity of care between a practice and its patients through telehealth.
- Allow practitioners offering telehealth services from their home to continue reporting their work address on their Medicare enrollment to avoid privacy and security concerns.

The *CONNECT for Health Act of 2023* (H.R. 4189) would accomplish many of these priorities such as permanently removing geographic and originating site restrictions, eliminating the six-month in-person requirement for telemental health services, and more. Enacting this bipartisan legislation would be a great step to advancing patients' access to care at home in rural and underserved communities.

During COVID-19, CMS allowed practitioners to offer telehealth services from their homes while maintaining Medicare enrollment from their work addresses. This policy was extended through the end of this year in the 2024 Medicare Physician Fee Schedule. MGMA believes that home reporting requirements for practitioners offering telehealth services from home should be eliminated so that they may continue to report from their work address. This mitigates significant privacy and security concerns as this information may be available to the public. It also alleviates the undue administrative burden of having to update Medicare enrollments for every practitioner that would divert critical medical group resources away from clinical care.

The *Medicare Telehealth Privacy Act of 2023* (H.R. 6364) would direct the Secretary of Health and Human Services to make sure that practitioners' home addresses are not made publicly available. This is a good first step, but allowing practitioners to continue reporting their work addresses would alleviate all the difficulties associated with home address reporting.

MGMA looks forward to working with the Committee to ensure medical groups can continue offering telehealth services to patients in their homes across this country. If you have any questions, please contact James Haynes, Associate Director of Government Affairs, at jhaynes@mgma.org or 202-293-3450.

Sincerely,

/s/

Anders Gilberg
Senior Vice President, Government Affairs

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KNOWLEDGE CONQUERS CANCER

Everett E. Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

Statement prepared for:
U.S. House Committee on Ways and Means

Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

March 12, 2024

The Association for Clinical Oncology (ASCO) is pleased to submit this statement on enhancing access to care in rural and underserved areas. Geography is a significant barrier to access for many patients with cancer, jeopardizing their chances of a successful outcome. Among these are financial and workforce issues that challenge development of health care infrastructure in rural communities and long distances that make it hard for patients to obtain and sustain treatment in urban areas.

ASCO is the world's leading professional organization representing nearly 50,000 physicians and other health care professionals who care for people with cancer. As outlined in our mission, we strive to conquer cancer through research, education, and promotion of the highest quality, equitable patient care. We appreciate your efforts to protect patient access to lifesaving and life-prolonging treatments for all patients with cancer, including those in rural and underserved areas of our country, and we look forward to working with you and your staff to make these and other meaningful solutions a reality.

Cancer patients living in rural areas of the United States (U.S.) are diagnosed at late stages of their disease, do not receive chemotherapy in a timely manner, and may forego care altogether. Specialty care may not be available in rural areas. Oncologists who do serve in rural communities often have trouble accessing ancillary services vital to delivery of cancer treatment—equipment must be borrowed or scheduled for "circuit" rides, may be derailed because of weather or other events, or is fully occupied in the home facility. Patients who cannot travel hundreds of miles for required ancillary services may simply forego them.

Many factors influence the supply of and demand for oncology services, including changes in the incidence and prevalence of cancers, population demographics, insurance status and type, and changes in physician retirement rates and productivity. Future demand for oncology services in the U.S. is

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expected to rise rapidly, driven principally by the aging population and a projected increase in the number of cancer survivors requiring ongoing monitoring and care. At the same time, the current oncology workforce is aging and heading into retirement in increasing numbers; in 2022, more than 1 in 5 oncologists were nearing retirement (aged 64+).[1]

Geographically mismatched demand and supply also characterize the current oncology workforce. The oncology workforce is concentrated in a small number of urban counties – and most rural counties in the U.S. have no medical oncologist.[2] Inadequate supply of health care professionals may contribute to cancer health disparities, as a lack of access to resources available to diagnose and treat cancer is a major hindrance to the equitable delivery of care.

Oncology workforce shortages are more significant in rural and underserved areas, as many facilities have difficulty attracting and retaining health care providers. According to workforce data from the U.S. Health Resources and Services Administration, non-metro oncology supply will only meet 37% of demand by 2035.[3] Additionally, only 10.5% of oncology practices are in rural geographic areas. A 2021 study shows that 64% of counties in the U.S. had no oncologists with a primary practice location in that county. Twelve percent had no oncologists, either within the county or in adjacent counties. When cross referenced by the corresponding cancer rates, the study found a negative association between the availability of oncology workforce and cancer rates.[4]

Telemedicine has helped, not only to bridge the gap in care for rural patients but also enhancing access to care in general. This was especially important during the COVID-19 public health emergency when face-to-face interactions were limited. The use of telehealth has proven beneficial to providers and patients by increasing access to care for patients with cancer while reducing treatment burden and disruption to patient lives. The expanded use of telehealth has also helped providers reach historically underserved populations, including rural populations and those that might find the need to take off work, find childcare, and arrange transportation to an in-person visit prohibitive.

We support efforts to permanently lift the geographic and originating site restrictions for telehealth in Medicare, such as the *CONNECT for Health Act of 2023* (H.R. 4189/S. 2016). This bill, introduced by Ways and Means members Rep. Mike Thompson (D-CA-4) and David Schweikert (R-AZ-1), and cosponsored by several additional members of the Committee would permanently remove the geographic and originating site restrictions, permit remote patient monitoring, allow use of telehealth in community health centers and rural health clinics, and provide reimbursement for those services. These restrictions had previously meant telehealth services were only covered for patients in rural areas at eligible sites

[1] https://ascopubs.org/doi/pdf/10.1200/OP.20.00577
[2] https://ascopubs.org/doi/pdf/10.1200/OP.22.00168
[3] https://data.hrsa.gov/topics/health-workforce/workforce-projections
[4] Shih YT, Kim B, Halpern MT. State of Physician and Pharmacist Oncology Workforce in the United States in 2019. JCO Oncol Pract. 2021 Jan;17(1):e1-e10. doi: 10.1200/OP.20.00600. Epub 2020 Dec 3. PMID: 33270520; PMCID: PMC8189614.

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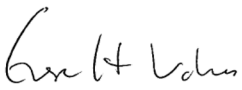
(doctor's office/clinic). ASCO appreciates Congress' extension of telehealth flexibilities for services through 2024 and encourages policymakers to make these flexibilities permanent.

Thank you for holding this important hearing. We welcome opportunities to engage with the Committee on Ways and Means in a meaningful dialogue about these issues as you continue to work to address rural health care disparities. Thank you for your commitment to improving health care for patients in rural and underserved communities. If you have any questions, please contact Kristine Rufener at kristine.rufener@asco.org.

Sincerely,



Everett E. Vokes, MD, FASCO
Chair of the Board
Association for Clinical Oncology

Testimony

The U.S. House of Representatives
Ways and Means Committee

Rep. Jason T. Smith, Missouri, Chair
Rep. Vern Buchanan, Florida, Vice Chair

Hearing on Enhancing Access to Care at Home in Rural and Underserved Communities

Thank you, Chair Jason T. Smith for the opportunity to provide written testimony in support of enhancing access to care at home in rural and underserved communities. I have been on home dialysis since 2001 and I am passionate about the benefits of home dialysis and its positive impact on lifestyle and decreased mortality risk. Because of the energy that I have with home dialysis versus three times a week in-center dialysis, I've been able to be a long-time advocate for other patients looking to find their best life with End Stage Kidney Disease (EDSK) while on dialysis.

I'd like to share some of my personal journey while listing some observations that I have made over my nearly quarter of a century of dialyzing at home. While there have been significant struggles for me, my wife, and our children along the way, including for me personally depression, early on suicidal thoughts, struggles with anemia, difficulties with infections, and issues surrounding the burden of home dialysis, I wouldn't have it any other way. I'm able to write this letter and share my thoughts with you and the Committee, because home dialysis has been my gift of life. The positives of home dialysis have far exceeded any negatives that we have had to endure. While the struggles we have had are compelling in detail, I will save them for another time and keep my observations short and to the point.

1. **New dialysis systems have made home hemodialysis easier.** When I first started home hemodialysis in 2001, thanks to the foresight of my University of Michigan dialysis clinic nephrologist, I had to have a pressure regulator and pump placed on my home plumbing system to ensure the appropriate pressure from the street to the newly installed reverse osmosis system. This system supplied clean water to my full-size dialysis system, which used it to make dialysate to be used by the machine to clean my blood and remove excess fluids. At this time, this was the only way to do home hemodialysis. Now, there are two different approved home hemodialysis systems, each with their own much smaller water purification systems that don't require extensive plumbing additions. Because of this, the current systems each now have a much smaller footprint. Also, the supplies one would have to store in our house, from one manufacturer which received federal approval in the early 2000's, were greatly reduced because of its water purification/dialysate production system that was approved in 2008. Innovation is needed to make dialysis machines that are easier to transport, simpler to operate, and that will allow for more flexible prescriptions.

2. **There is a burden on the user and the care partner.** Using that full sized machine put a particular burden on my wife, who trained to operate the machine and was now my care partner in a way that we had never imagined when we fell in love at the age of sixteen years old. After ten years of enduring miscarriages and infertility, we were fortunate to have adopted our son, Jacob, when he was born. We had recently moved to East Lansing, Michigan for my new job, and Andria had planned to stay home to

care for Jacob. When I switched to our new home system from the U of M in-center dialysis clinic, I went back to work. My dialysis prescription called for me to do dialysis five days a week so that I would feel better than what I had when I went in-center three times a week. And I did feel better. But at that time, Andria took care of most of my dialysis needs. She would set up the machine, cannulate me, hook me up to the machine, respond to any alarms while tending Jacob and making dinner, take me off the machine, then disinfect the machine, and finally break it down. This was a lot of work, but it allowed me to continue to make a living for are our family. When we travelled, I would go into a dialysis center nearby to where we were staying. This gave Andria a well needed break from keeping me alive but kept me away from the family for at least five hours on the three days I dialyzed. Care partners need support in their duties and the opportunity for respite.

3. **It is important for the person dialyzing to participate in their treatment to the best of their ability.** After dialyzing more frequently with the full-size machine provided to us by the U of M, with Andria doing nearly all the work, I felt stronger, more independent, and I had more energy. I came to realize for me to feel this way that I was placing too much pressure on Andria. I talked with my nephrologist who then prescribed peritoneal dialysis (PD) for me. This time I said yes. When I first crashed into dialysis at the end of 2000, this same nephrologist had suggested that I consider starting with PD. Now this was rare in the early 2000s to be provided to start on PD so early in the need for dialysis. At the time and even now, many patients are simply sent to in-center dialysis without being made aware of home modalities.

After they explained that they would place a catheter in my belly and that I would have to do PD every night with a bedside machine while I slept, I had initially felt that it was too daunting. I also was uremic at the time, feeling the symptoms of too many toxins in my blood, one of which is brain fog. Also, knowing then that I would have a transplanted kidney in five months, it seemed like too much work compared to just going to a center three-times-a-week. I didn't realize at the time that I would feel much better with daily dialysis at home–which is especially important while waiting for a kidney transplant. That the toxins and fluid would be taken out much more frequently and not be allowed to build up as with traditional in-center dialysis. But, once I was cleaner and stronger due to more frequent home hemodialysis performed by my wife, and that the transplant that I received from Andria was immediately shut down due to my underlying disease of focal segmental glomerulosclerosis (FSGS), I realized the PD would greatly relieve the burden of caring for me. Even though it was a huge storage burden, I was feeling great, and travel now allowed for me to stay with my family. Heck I even did manual exchanges of dialysate inside the Magic Kingdom's first aid room while on a family trip. With PD as my system, Andria and I adopted our daughter, Antonia, from birth in another open adoption. This was during my fourth year of home dialysis. Dialysis patients need to be given the opportunity to take control of their dialysis options in order to improve their quality of life.

4. **We must remove racial disparities in dialysis.** When I crashed into dialysis, I was a thirty-six-year-old man living in East Lansing near the capital city of Michigan. Because our son and our daughter are both Black, I was learning about my white privilege. I will soon be fifty-nine. When I first found myself on emergency dialysis, I also found out at the time that the average lifespan on in-center dialysis was seven years. With home hemodialysis, my wife and I were fortunate to expand our family and be there every step of the way through their high school graduation and into them becoming the incredible young man and young woman they are today. Through this journey I am now completely aware that my white privilege has made my opportunity for transplant and for my longevity on various means of home dialysis possible. Whether this played a role with my own personal providers I cannot tell, though I am doubtful based on the individuals that I came know, but rather it may have played a role in systems in which they were working, and in the dialysis medical community as a whole. My family is now made up of two white adults and two black adults. I want to ensure my children, who because of their ethnicity are at a

higher rate of acquiring kidney disease, will not suffer through racial disparities to get the same treatment if needed that I received.

5. **Lower mortality risk matters.** I used PD up until I received another kidney transplant in 2005, this time from a deceased donor. Fortunately, I was able to join the transplant waiting list in two different states. This isn't the case for everyone in need of a transplant. The barrier of distance often can't be overcome due to access to and means for transportation. I received my new kidney transplant at the University of Wisconsin Hospital in Madison where unfortunately my underlying disease of FSGS began to shut it down immediately. After six-weeks undergoing plasmapharesis, it later was infected, and like the kidney donated by Andria, was removed. For many of the nearly 500,000 people on dialysis in the US, transplants may not be an option. And for us dialysis is our gift of life.

I came back to East Lansing and began in-center dialysis with a large dialysis provider organization. Soon after starting, I learned about a rather new transportable hemodialysis machine which used sacks of dialysate, similar to the PD machines, which allowed for travel without having to go in-center. I spoke with my new nephrologist about it, and she agreed that I would make a good candidate. My current dialysis center didn't offer it and I had to go to a center operated by a different large dialysis provider organization in Flint. This center is nearly an hour away by car. Again, fortunately I had the means to make the daily commute for the next three to four weeks for training. Since I was no longer working due to disability based on ESKD, I also had the time to do the training. If I had still been working, their daytime training schedule would have been difficult for me to attend. With this training, my wife had to take time off work for a week to be trained on this system. It was my plan to do this type of home hemodialysis independently with Andria being there as back up if needed. And that is how it has been.

After three days of training, I felt significantly more energy. I did dialysis six days a week at a time of my choosing that worked for our family for about two and a half hours each treatment. I was even more active with our children than I was on PD. Two years after starting with this new machine, I learned from other users that nocturnal use would be even better by being gentler on my heart, cleaning toxins that were hard to remove at higher speed more frequent dialysis, and would free up my days. With my nephrologist's backing and support, I switched to a small dialysis provider organization in downtown Detroit. After just a week of training for some additional safety procedures, I started doing home hemodialysis for eight hours five nights a week while I slept next to my wife, with the kids asleep down the hall in their rooms. Research has shown that nocturnal home hemodialysis provides the same mortality risks as does a deceased donor transplanted kidney. My goals from day one of dialysis back in 2001 were to live an incredibly good quality of life for a long time. And that is what I am doing with nocturnal home hemodialysis.

In closing, despite the lofty goals for having more ESKD patients adopt home dialysis as spelled out in the 2019 Advancing American Kidney Health Initiative, there are still many barriers to home dialysis uptake including the following:

1. Inadequate level of training and exposure among nephrology professionals.
2. Care partner burnout.
3. Inadequate information and training of patients.
4. Inadequate number of home dialysis centers, or in-center facilities offering home dialysis options.
5. Inadequate number of staff to train those wishing to switch to home dialysis.
6. Access to transportation to training at home dialysis centers.
7. Lack of available assistance to those wishing to dialyze at home but may not be able to physically preform it on their own.
8. Rules requiring only nurses to provide the training.

These must be tackled to ensure that all ESKD patients can have and meet the goals of living a good quality of life for a long time. I look forward to working with you and your fellow Committee members and others to address these barriers to improve home dialysis access care to rural and underserved communities.

Thank you for your time.

March 26, 2024

The Honorable Jason Smith
Chairman
House Committee on Ways and Means
Washington, DC 20515

The Honorable Richard Neal
Ranking Member
House Committee on Ways and Means
Washington, DC 20515

Submitted electronically at WMsubmission@mail.house.gov

Dear Chairman Smith and Ranking Member Neal,

LeadingAge is submitting this statement for the record in response to the March 12, 2024 hearing on *Enhancing Access to Care at Home in Rural and Underserved Communities.* This hearing highlighted critically important gaps in service in rural and underserved areas and bipartisan policy solutions to address some of them. LeadingAge appreciates the ongoing support of members of the House Ways and Means Committee in assessing and promoting access to the full continuum of aging services for older adults and we appreciate the opportunity to submit feedback for the record.

We represent more than 5,400 nonprofit and mission-driven aging services providers and other organizations that touch millions of lives every day. Alongside our members and 36 partners in 41 states, we use applied research, advocacy, education, and community-building to make America a better place to grow old. Our membership encompasses the continuum of services for people as they age, including those with disabilities. We bring together the most inventive minds in the field to lead and innovate solutions that support older adults wherever they call home.

Other Home-Based Care Services in the Committee's Jurisdiction
We were disappointed that the hearing was not able to bring in other home-based care services in the Committee's jurisdiction like home health and hospice. For example, home health organizations are critical partners in the hospital at home model (detailed below) and having witnesses explore with the Committee how these models work together and where they differ would have been helpful for Members to hear. We hope that the Committee has future hearings on both Medicare home health and hospice – both as they relate to the greater ecosystem of care at home and also on the individual benefits. We were grateful that some Members brought up bills and initiatives related to home health – for example, Mr. Smucker's discussion of his bill, *The Medicare Home Health Accessibility Act (HR 7148)* on occupational therapy and home health is one we support and hope to see marked up in the near future.

Caregiver Support in Home-Based Care Models
LeadingAge and our members support opportunities for innovation and were pleased to hear the testimony on the effectiveness of models like home dialysis, hospital at home, and other opportunities around remote patient monitoring. The testimony, especially that of Ms. Maddux,

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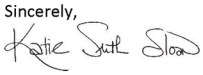
underscored that these models need to price in the cost of training for patients and for family caregivers. The expansion of care to the home and the use of technology to support that expansion makes sense and is inevitable as we face severe staffing shortages. But what we are seeing today is increasingly complex care being hoisted onto patients and families with less support. As we expand on the models of care discussed at the hearing, money needs to support training, education, and methods to provide emergent support as well as direct care provision.

Hospital at Home
LeadingAge supports the extension of the hospital at home waiver. There are an increasing number of hospitals becoming confident with the waiver and how it can positively impact their organization and their patients. This waiver also leverages post-acute care providers integration with the larger system. Home health care is the ideal partner as agencies are already well-established in the home environment and connected to all the points of care for a patient in their home. For hospitals this partnership can increase capacity, patient satisfaction, and quality outcomes while reducing cost without cutting into their already limited staff, many of whom are burning out and not comfortable in the home environment. Through this type of partnership, home health can participate in shared savings and quality incentive programs in ways agencies have not had the ability to do in the past. We support extending the program and conducting more analysis into the partnerships formed between hospitals and home health agencies to understand the leverage of knowledge and the incentives of shared savings. We believe at additional analysis will find the partnerships between these two entities will have the strongest outcomes.

Telehealth
A message that came through loud and clear during the hearing was ongoing support for telehealth. LeadingAge agrees – telehealth has become ingrained into the healthcare system and there is no going back. The expansions in the *CONNECT for HEALTH Act of 2023 (HR 4189)* and the recently reintroduced *Telehealth Modernization Act of 2024 (HR 7623)* are ones we endorse.

If you have any questions about LeadingAge comments, please contact Mollie Gurian at mgurian@leadingage.org

Sincerely,



Katie Smith Sloan
President & CEO